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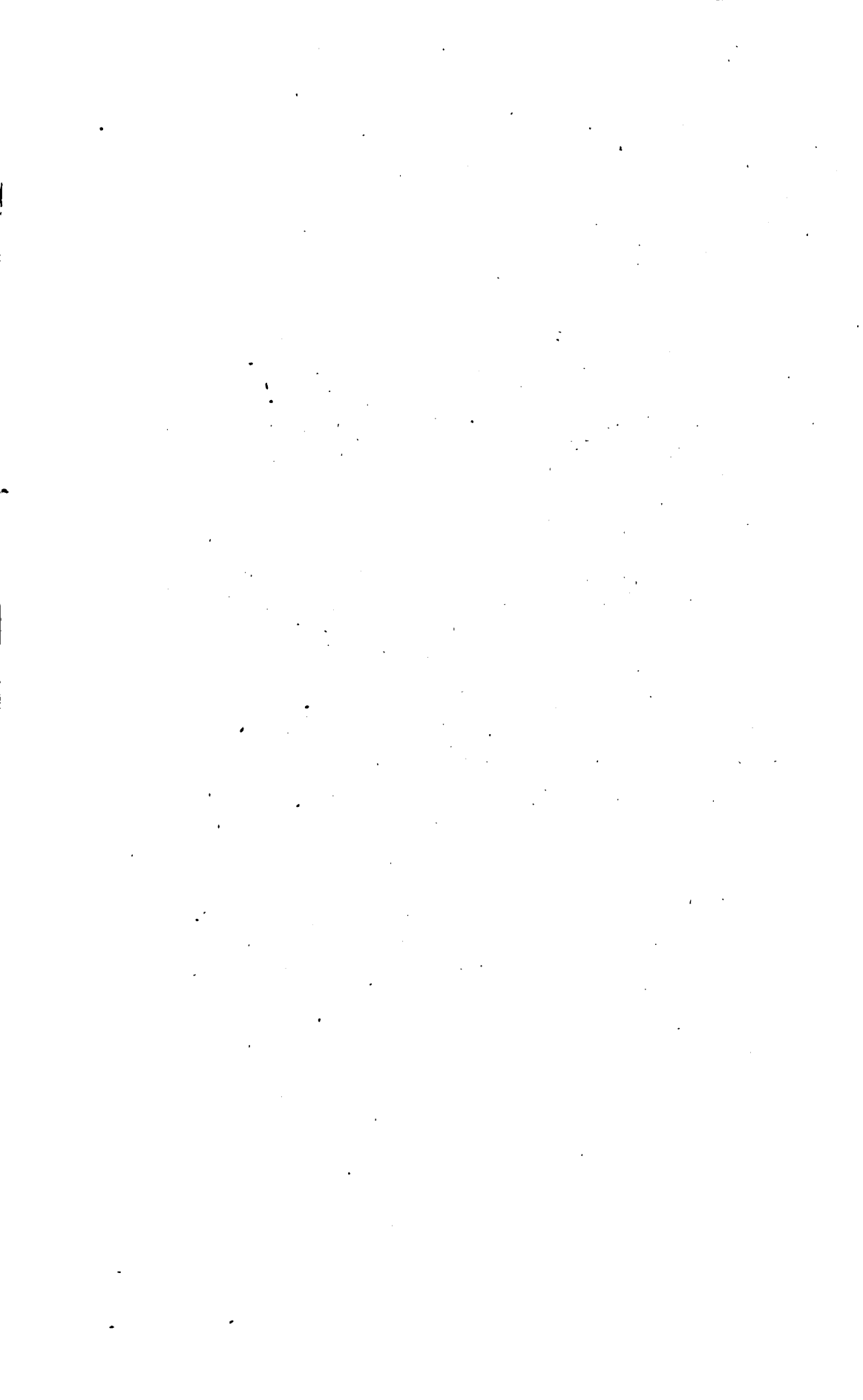
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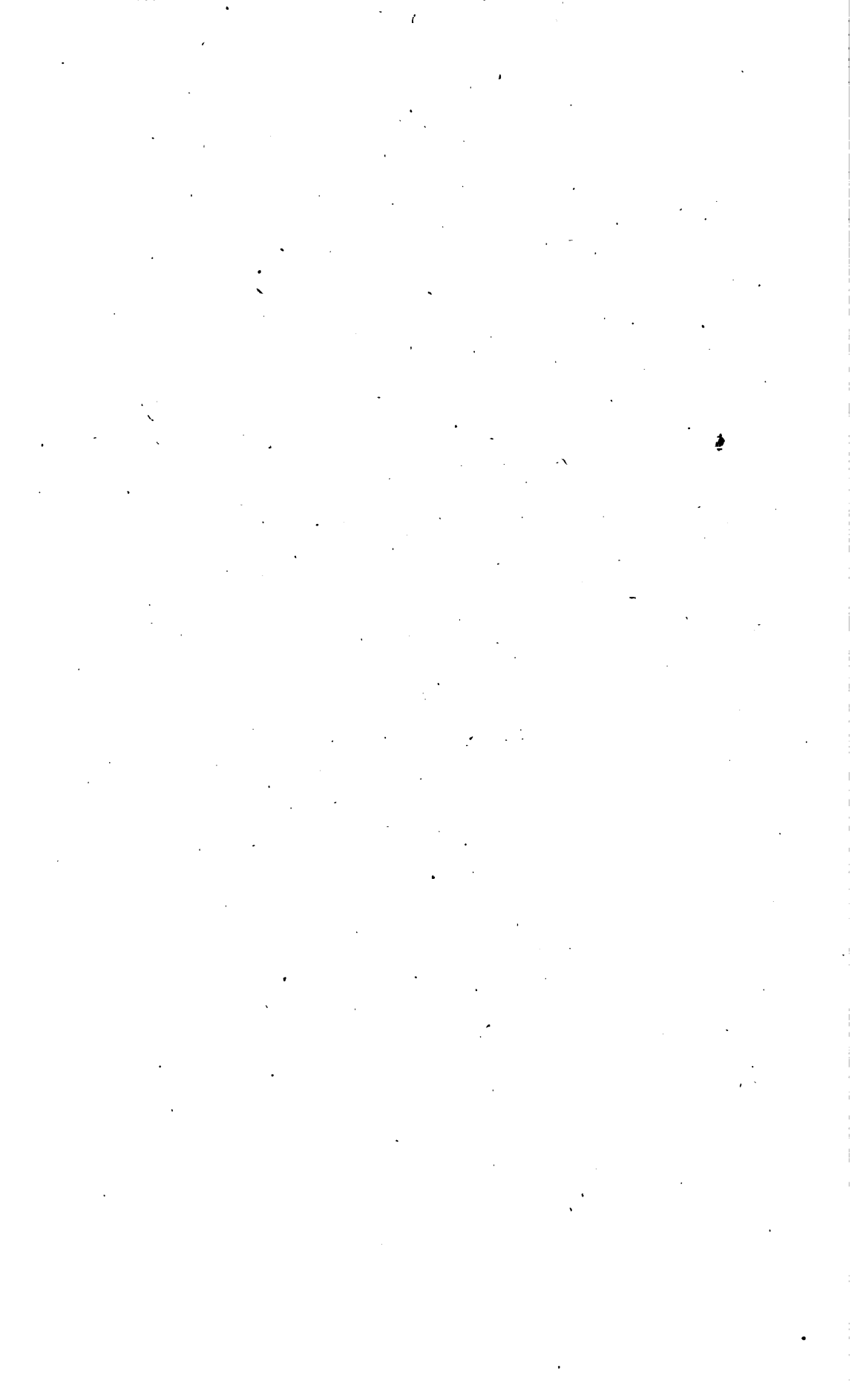
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THE
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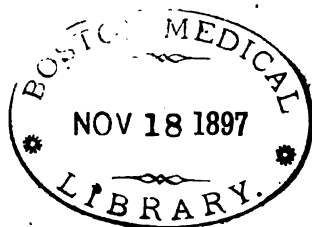
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PUBLISHED ON THE 1ST AND 15TH OF EACH MONTH.

VOL. IV.—1857.

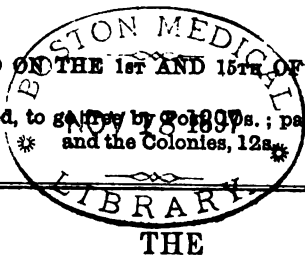
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TO OUR SUBSCRIBERS.

AT the commencement of another volume, the fourth of our New Series, we beg to submit again to our Subscribers the Prospectus which we originally published.

"The Proprietors, in resuming the publication of the Journal under this name, have much gratification in stating, that a considerable number of Physicians and Surgeons of the majority of the Dublin Hospitals have already co-operated to contribute materials for its pages; and they confidently anticipate that when the purpose of the Journal is fully understood, it will obtain a similar support from Physicians and Surgeons generally, not only in Dublin, but throughout the kingdom.

"The DUBLIN HOSPITAL GAZETTE will be mainly devoted to the cultivation and improvement of Practical Medicine and Surgery, through the publication of carefully recorded cases, with clinical observations, which otherwise might be forgotten or lost, or might be only applied to temporary clinical instruction, but which, preserved in the pages of this Journal, will form an authentic record, and accumulation of facts, that will constitute the best materials for future more lengthened and elaborate essays. Each Number will further contain a summary embodying the most important discoveries in Medicine, Surgery, and the collateral sciences, as they appear in this and other countries.

"It is scarcely necessary to observe, that with its exclusive appropriation to such objects, and deriving support from so many quarters where differences of opinion may exist, this issue of the DUBLIN HOSPITAL GAZETTE will rigidly follow the

principle acted on in its preceding Series, of having no place for politics; nor will it admit any observations or discussions of a personal nature.

"It is hoped this Journal will prove instructive to students, more especially of the Irish School, who may, in the perusal of its pages, be enabled to recall more vividly to their recollection many of those cases which have come under their own observation in their hospital attendance, and that to members of the profession, engaged in the laborious occupation of practice, its contents may not prove uninteresting, coming to them with the public stamp of hospital authenticity, and frequently from sources where they themselves had received their education.

"The Proprietors hope that an Irish Journal, conducted on such principles, and with such objects, will obtain the approbation of the Profession."

The encomiums passed by various British and foreign periodicals on the contributions made to the GAZETTE, the numerous extracts from its columns, and the rapidly-increasing number of its Subscribers, all attest that our hope has been fully realized.

In order, however, to carry out these views as efficiently as possible, an entire revision has been made in the management of the GAZETTE, a large amount of co-operation has been secured, and it has been determined to issue, at short and regular intervals, well-arranged and ample contributions on the progress of Medicine, Surgery, Midwifery, Pharmacy, and all the collateral sciences. These will form a new, and, it is to be hoped, a valuable addition to the present Series.

WHITWORTH & HARDWICKE HOSPITALS.

ILLUSTRATIONS OF CARDITIS, WITH REMARKS.

By Dr. M'DOWEL, Physician to the Hospitals.

No. 1.—*Pericarditis and Endocarditis, occurring in the course of Acute Rheumatism. Death on the ninth day.*

J. M., a pale delicate looking boy, aged 11 years, was admitted into the Hardwicke Hospital under Dr. M'Dowel's care, November 19th, 1856, labouring under rheumatic fever. Two years ago he had been similarly affected. The present attack set in on the 16th November; at the time of his admission, three days afterwards, the disease was fully established, the characteristic fever was present, and the knee joints were red, swollen, and painful. On the 23rd the patient complained of pain and uneasiness in the cardiac and sternal regions, but the sounds and impulse of the heart were unaltered. On the 25th the expression of the countenance indicated the existence of pericarditis, and *frottement* was now strongly developed. The arthritic inflammations did not however now terminate, for on the 26th the wrist joints became affected. On the 27th a tendency to sinking was observed, the pulse became smaller and more rapid, and the face extremely pale; wine and diffusible stimulants were given. On the 29th the breathing was hurried and so difficult, that the boy was unable to lie down; the feet were slightly swollen, and inclined to be cold. These symptoms did not depend, as was at first supposed, on pericardial effusion, for there was no increase of dulness over the pericardial region, and *frottement* was as distinctly and as extensively heard as before, and in the erect as well as in the horizontal position of the body. On the 30th the pulse was scarcely perceptible, and extremely rapid, the face was dusky, the voice very feeble, but the intellect remained wholly unaffected up to the time of death, which took place very early on the morning of Dec. 1st.

Post mortem examination, eight hours after death.—A few ounces of clear amber-coloured serum were found in the pericardium. Both surfaces of the serous membrane were thickly coated with rough lymph, and were singularly vascular. Lymph was sparingly but distinctly deposited on the inner or opposed surfaces of both the aortic and mitral valves; but was only found on those portions of the valves which come into mutual opposition. The lower margin of both leaves of the mitral valve was thickened, and presented a remarkable beaded appearance ("fibroid thickening"). On the sigmoid valves, the lymph was not deposited in a linear manner, as has been described by Dr. Watson, but was thickly scattered like grains of sand over their surfaces of contact. No change was visible in the muscular tissue. It was remarkable that soft adhesions had already formed round the base of the heart, so that the

disease and its natural mode of cure were actually progressing *pari passu*. There was limited pleuritis on the right side.

Remarks.—In this instance the disease ran its course to a fatal termination with unusual rapidity; death occurred on the ninth day from the time when the boy first complained of uneasiness about the heart, and on the seventh day from the occurrence of *frottement*, and was chiefly owing to *nervous shock*, but partly, perhaps, to the implication of the muscular tissue inducing a certain amount of paralysis.* Mercury was gently given as soon as pericarditis was only suspected, and a blister was applied over the region of the heart, but diarrhoea soon came on, which obliged the mercury to be discontinued. Another unfavourable sign was, that the pulse increased in frequency, whilst it decreased in strength. This was the forerunner of vital exhaustion, which became very evident as early as the fifth day, and which the stimulants then freely given, failed to combat. Carditis rarely proves fatal in the manner exemplified by this case, and a knowledge of this source of danger at so early a period of the disease, should make us cautious in adopting any very heroic mode of treatment, especially as all experience shows, that in the great majority of instances pericarditis tends naturally to recovery. In connection with this remark, the fact that adhesion of the opposed surfaces was actually making rapid progress, when death from asthenia occurred, has perhaps some significance. In the treatment of such a case an observation of Dr. Seymour's occurs to me which is very applicable, to the effect, that we should not employ all the artillery of physic if gentler means will suffice, because there is no need to batter down a town if we can reduce it entire.†

No. 2.—*Endocarditis secondary to Chronic Valvular Disease, and Chronic Myo-Carditis; Acute Ulceration of the Aortic Sigmoid, and of the Mitral Valves; Acute Oedema of the Lungs.*

A carman, aged 27 years, of intemperate habits, came under Dr. M'Dowel's observation, Nov. 14, 1856, labouring under combined pulmonary and cardiac disease. He was too ill to allow us to learn more than that for some time he had suffered from many of the usual symptoms of morbus cordis, but had been always able to follow his occupation until lately, when a heavy cold which he contracted obliged him to apply for relief. On admission he was labouring under extreme dyspnoea; he was wholly unable to lie down; the face was bloated, the lips were livid, the jugular veins were greatly distended, and the feet and legs were slightly anasarcaous; there were the signs of extreme

* "Third form" of Pericarditis.—Stokes.

† I am unable to call to mind where this observation is to be found, or to what subject it was applied. The meaning may not therefore have been given as correctly as I would have wished.

congestion and of œdema of the lungs. The heart beat with much force, and over a large surface; the pulse at the wrist was disproportionably small, but regular. No *bruit de soufflet* could be distinguished. Six or eight ounces of blood were taken from the arm, whilst diffusible stimulants were given internally; some little relief was experienced, but the dyspnœa soon became as intense as before; a drowsiness came on, and the patient died in a semi-comatose condition on the third day after his admission.

Post mortem examination, 24 hours after death.—The lungs presented the most extreme degree of œdema and congestion; they were of large size, quite tough, and incompressible as if carnified, whilst they floated lightly in water; when cut into, great quantities of frothy serum flowed away.

The heart was much enlarged; the right cavities were much dilated, and their walls thickened, especially the walls of the right ventricle. The left auricle was hypertrophied and dilated; the left auriculo-ventricular opening was diminished about one-third its usual dimensions. The flaps of the mitral valve were much thickened, and the *carneæ columnæ* hypertrophied; the muscular tissue of the left ventricle was in many places, near its base, much *indurated*, from having been infiltrated with a whitish substance like lymph; the aortic valves were likewise much thickened and indurated.

These changes were obviously of old date. But traces of *recent inflammation* were superadded. The valves were swollen and of a *delicate pinkish colour*. Lymph was effused, as in the former case, on the opposed or inner surfaces of both the aortic and mitral valves, and also in small thin shreds on the surface of the septum from which it could be easily brushed off. Ulceration had likewise attacked the valves, and two perforations of considerable size had occurred from this cause in the anterior mitral leaf; a similar number of openings, but of smaller size, were found in the sigmoid valves, near their free edges. Around the ulcerative openings, lymph had been very freely poured out, so as in all probability to have prevented any blood from passing through them during life.* These perforations were altogether different from those which are sometimes met with as the result of *atrophy* of the valves, where the structures immediately around the perforations are reduced to the greatest degree of tenuity, and where no appearances of inflammatory action are present. It has been stated that no bruit existed during the last few days of life, yet the elongated form, and hypertrophied conditions of the left ventricle indicated that aortic regurgitation had

existed for some time, but it is probable that the thickening and swelling of the valves consequent on the *recent* attack of endocarditis, may have rendered the valves once more efficient, and by preventing regurgitation, have caused the murmur to cease. According to this view an actual *increase of aortic valvular disease may coincide with a diminution or disappearance of physical signs*, a combination which has not unfrequently been observed in cases of mitral narrowing.

It is as yet a disputed point whether the material which is effused on the endocardium in such cases is an inflammatory exudation from the inflamed membrane, or a mere fibrinous deposition on the surface. In Case 2, the evidences of endocarditis were altogether unequivocal; but independently of this, the limitation of the lymph effusion to the *opposed surfaces* of the valves, (as in Case 1,) indicates its inflammatory nature; for a mere fibrinous deposit would be even more likely to be found on the outer surfaces of the valves, or to be entangled between the *cordæ tendinæ*; but in the cases detailed above, there was no deposit in either of these situations.

ON ELEPHANTIASIS OF THE SCROTUM, WITH AN ACCOUNT OF THE OPERATION FOR ITS REMOVAL, UNDER THE INFLUENCE OF CHLOROFORM.

By DR. O'BRIEN, (Calcutta.)

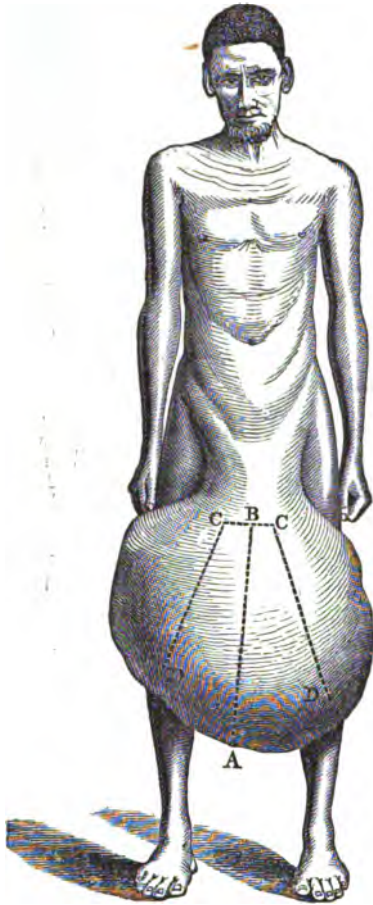
The following communication from Dr. O'Brien has been in our hands for some time, but we have deferred its insertion until we could accompany it with a woodcut.

"Calcutta, July, 1856.

"* * * I have now charge of two hospitals—one for Europeans only, the other exclusively for natives. The one is for the officers, engineers, and stewards, &c., of the Peninsular and Oriental Steam Navigation Company; it is the smallest but nicest hospital in Calcutta, or rather near it, for it is three miles from town. Here the usage is, to mix cases indiscriminately—cholera, fever, dysentery, &c. I have had only three cases of cholera now in twelve months; fever is constantly in the wards. Authors may speak of tropical fevers, but the treatment that obtains at home will do so here also. Doctor Corrigan's divisions into the lesions of the functions of nutrition, circulation, and the cerebrospinal system, are particularly remarkable here, and the urine cloud is most *emphatically* developed in the different stages. Calcutta is full of fever just now, and it is rather fatal, and generally on the fifth or sixth day. This is the most unhealthy season that I have spent here. The most burning sun in dry weather is not half so bad as the rainy season. The second hospital is one for natives, and only a particular description of disease ever seeks admission—that is, elephantiasis of the scrotum, which requires to be removed to allow the man to work or walk, &c. I have removed twenty-two since

* Dr. J. C. Williams's description of acute ulceration of the valves was strictly applicable in this instance:—"The ruptured and ulcerated portions [of the valves] are found loaded with ragged, soft, fragile vegetations, and these are also sometimes seen adhering to adjacent parts where the endocardium is entire; the remaining parts of the valves are much thickened, and opaque, yellowish white, with a pink hue."

my appointment to the hospital; I send you a photograph of the largest, weighing 90lbs. The operation is simple, but formidable, as from the outer



[A, orifice for flow of urine; A B, first incision; C D, C D, second and third incisions; B C and B C afterwards separated, when the rest was removed by a catlin, as described.]

orifice you must cut until you feel the glans penis, which in this case was thirteen inches deep. Having found the glans, you dissect the penis from the tumor down to the root, and then you cut upon both testes, and clear them of the surrounding matter; and having safely placed the penis and testes on the pubis, with a catlin you remove the remainder of the tumor, leaving near the anus as much healthy integument as possible, as, during the sloughing process afterwards, irritation sometimes extends to the rectum, and causes dysentery. I lost only three of my cases. The dimensions and measurement of this case are:—

			Ft.	In.
Height of man	...	...	5	10½
Length of tumor	...	...	2	0
Circumference of do.	...	...	5	4

Weight, including hydrocele, 90lbs.

There is hydrocele in almost every case. This operation is very common in this country; it (the tumor) commences in a fever, which comes on every

new moon; and at each attack it enlarges; but if a native of the plains (who are alone liable to it) go to the hills, it is almost invariably immediately arrested; but if he return to the plains, even after nine or ten years, it again commences to enlarge. I also enclose a rough sketch, with a description of the incisions. The operation is always performed under the influence of chloroform. I have another large case, 60lbs., to remove within the next week. In speaking of the operation, I should have told you, that the reason for the very long incisions is on account of the great density of the tumor; and you must cut to the very bottom, to widen the gap, to seize the testes in order to clear them. On my visit this morning to the hospital, I found another tumor case before me, also very large; and it is in the person of a surgeon-barber, a common calling in the zillas or villages here: that is, the native doctor shaves &c. all the nawabs, rajahs, baboos, &c.; the inferior barbers attend the other inhabitants; for no one shaves himself here, except a few. As the mail will not go until August 9, I will leave my letter open.

24th.—I have operated on one of the cases, weighing 50lbs., and it has turned (so far) out well; and it is a case not devoid of interest, as, from the nature and duration of the tumor, I feared what often happens in such cases—death from a triple cause: viz., shock, hæmorrhage, and chloroform, and I had an electro-galvanic battery ready at his head; my fears were all but realized; for though I was only four minutes at the operation, my assistant-surgeon told me the man was dead—his heart could not be felt; but placing one pole under his ear, and another, with a moist sponge, to the epigastrium, respiration was immediately re-established, and he became all right. The operation also reminded me that I had omitted something in describing it generally. The patient is not placed in the ordinary way for operations; the table and cushion are divided in the centre, and when he is under chloroform, the lower one, from his hips down, is removed, and his legs are spread asunder and placed on chairs; and the operator stands between them; and when the tumor is removed, and the arteries tied, the second part is again arranged for his legs. I now never operate without a battery ready, as when a man has such a tumor it naturally drags to a vast extent the anterior abdominal walls; and when the tension and pressure are removed, there is a relaxation of those tissues, and a consequent collapse of the diaphragm. I lost one such case, but they are common and many here. In my case yesterday, the man did not lose a pint of blood, and he was only four and a-half minutes under chloroform, and of which he inhaled only a drachm and a-half; so that, had he died, he could not have died of either of those causes, except that they prevented the functions being restored after the shock, as was most satisfactorily effected by alternate contrac-

tions and expansions of the chest by electro-galvanism (Smee's).

August 8.—The man is doing very well, and I have since removed two others.

THOMAS O'BRIEN.

Chouringhee, Calcutta.

CASE OF PYCÆMIA.

By M. DAVIDGE, Esq., of Clonmellon.

On the 29th November, 1852, I was called to visit Mr. D., a Swiss, æt. 52, living in the capacity of butler in a gentleman's family, in the county Westmeath. He was previously healthy, but had been suffering for two days from severe pain in the right side, which had been preceded by rigor, and was attended with fever. The pain appearing to be muscular, I prescribed a dose of calomel and colocynth, and a blister. On the following day I found that the pain had been relieved, but that the febrile disturbance was rather increased. On the first of December, constitutional symptoms being much the same, Mr. D., for the first time, directed my attention to the right hand, on the little finger of which there was a paronychia, to which he had, for the last three weeks, applied different poultices, but from which he now suffered extreme pain. After much persuasion he allowed me to open this freely. Purgative medicine was again administered, as the bowels were much constipated; and, as he complained of extreme restlessness and want of sleep, I gave him a morphine draught at bed time, which was repeated on the following night, with a pill of pil. hydrarg. gr. 3, pil. rhei. co., gr. 2. During the three following days the inflammation in the hand steadily increased; the wrist and forearm became much swollen, and several white pustules appeared on the dorsum of the hand. His febrile symptoms increased, his bowels were obstinately confined, he complained of severe cramps in the legs, and, notwithstanding the opiate, he got little sleep. On the 6th I made a deep incision along the whole length of the dorsum of the finger, and applied a linseed meal poultice.

Dec. 7th.—I met Dr. Hudson (then of Navan) in consultation, who stated his impression, that we had to deal with a case of poisoned wound. This view, in which I concurred, was at the time perfectly unsupported by the history of the case, so far as then ascertained; but was founded upon the appearance of the part, and on the constitutional symptoms, so characteristic of blood poisoning. The incision in the finger presented a deep gaping wound, into which I could have nearly placed my own finger; the sides of the cut being infiltrated with a solid gelatinous matter, the back of the hand and the wrist both enormously swollen, and evidently infiltrated with the same matter, presented half-a-dozen vesicles exactly resembling

those of glanders, or those known in dissecting wounds as Colles's pustules; the forearm was tense and swollen to near the elbow, but not discolored. There was no appearance of inflamed absorbents.

His face was sallow and dusky looking, his skin greasy and constantly perspiring, pulse quick and feeble, tongue thickly coated with a pasty fur, bowels confined, urine scanty, high-colored, and loaded with pink lithates. His restlessness was extreme, he complained of general weariness and malaise, and of constant pain and cramps in the lower limbs.

It was agreed to continue the nightly dose of blue pill and morphia, and to give decoction and tincture of bark in effervescence, every three or four hours.

On the 8th he had four evacuations from the bowels, which presented the cadaverous odour so often observed in cases of purulent absorption. On the 10th several new vesicles appeared on the hand. On the 12th he had a *severe rigor*. On the 13th, on examining the legs, we found puffy swelling and heat of both ankle joints, and a hard circumscribed swelling in the calf of the right leg. Stupes of decoction of poppy capsules and camphorated spirits were applied to the legs, and the bark was continued, with an increased dose of morphine at bed-time. In addition to these, it was agreed to use mercurial inunction cautiously.

On the 15th he had a *severe rigor*.

On the 16th Dr. Hudson again saw him with me, and in the course of our renewed inquiries as to the source of the evident blood poisoning, we ascertained, that on the 26th November, Mr. D., misunderstanding advice which he had received, to apply the membrane covering mutton suet to his whitlow, had cut off a piece of the hide of a sheep, two days killed, and wrapping this round the finger, had worn it for 24 hours; that before the expiration of this period he had felt shivering, followed by feverish symptoms, pain in the head and back, and by the weariness, pains in the limbs, and cramps, of which he has since so constantly complained.

We now prescribed a mixture of equal parts of Murray's camphor and yeast, with two grains of sulphate of quinine, three times a day. Wine and beef tea to be given liberally. The joints to be painted with tincture of iodine.

There was no marked change until the 21st, when slight ptyalism appearing, I suspended the inunction.

On the 22nd, we thought the constitutional symptoms slightly improved, while the appearance of the hand was much changed for the better, the infiltration and swelling having nearly disappeared, and the incision being disposed to heal. He had had no rigor since the 15th, but had constant perspirations. As there was a disposition to diarrhoea, the yeast mixture was discontinued, and infusion and tincture of bark with muriatic acid substituted. Wine and beef tea to be continued.

25th.—I discovered and opened an abscess over the sacrum.

27th.—I detected a purulent depot in the right knee, and on the 28th, another in the right hip.

Jan. 2nd.—Mr. D. complained of severe pain in the calf of the left leg, and on examination, I found a depot similar to that already found in the right, which latter I opened on the 10th,

13th.—*A severe rigor*, followed by sweating.

15th.—The discharge from the sacrum increasing; much perspiration and debility. In consultation with Dr. Hudson, it was agreed to give, with each dose of the bark mixture, two drachms of Donovan's syrup, and ten grains of chlorate of potass.

From this date to the 30th there appeared to be a gradual daily improvement in Mr. D.'s condition. The puffing of the joints disappeared, the abscesses in the legs having been opened, both healed, as did the incision in the finger. His face quite lost the sallow dingy hue, and became clear; hectic symptoms disappeared, he had no rigors or sweats, and in short, he seemed to have survived the pyogenic disposition, and to be recovering; but, just as every other symptom became favourable, the discharge from the abscess on the sacrum, which had previously diminished, began to become offensive and sanious; examination with the probe discovered a large portion of the bone to be bared. Not only did the discharge from this daily increase, but a new collection formed at the side of the coccyx, evidently extending into the pelvis, and causing irritability of the bladder, and extreme pain in making water.

There was no return of former hectic symptoms, no rigor or perspirations, but he had, every evening, vomiting of brown fluid, occasional diarrhoea, the stools becoming again offensive; his skin became sallow, he complained of noise in the ears, and of giddiness on raising the head from the pillow. On auscultation an anæmic murmur was heard with the heart's first sound. Up to within three days of his death he took food and stimulants freely, his daily allowance of wine ranging from a bottle to a bottle and a half, with brandy on ass's milk, jelly, beef soup, oysters, &c., &c. The signs of spanæmia became daily more apparent, blood corpuscles appeared in the urine, and on the last morning of his life he had rather copious hæmoptysis. He retained his intelligence to the last, and died quietly, on the evening of the 14th of February, eleven weeks after the imbibition of the poison.

During its protracted course, this case presented three features of interest, at different periods. The first, the apparent influence of mercury in producing healthy action in the hand; the second, the marked improvement in the constitutional symptoms from the 15th to the end of January, during which period the pyogenic tendency seemed to be arrested, and recovery all but certain; the last, when,

partly owing to the seat of the abscess, and partly to the exhausting effects of a drain in his enfeebled condition, a new set of symptoms set in, which seemed to be less those of pyæmia than of exhaustion from pain, want of rest, and copious discharge from the abscess of the sacrum.

PATHOLOGICAL SOCIETY OF DUBLIN.

The second meeting was held on Saturday, December 6,

The President, Dr. CORRIGAN, in the Chair.

DR. MAYNE exhibited to the Society

The Uterine Polypus removed by Dr. Shannon, by means of Chassaignac's Ecraseur.

Full particulars of this case, as published by Dr. Shannon, will be found at p. 369, vol. iii.

DR. BANKS gave the following particulars of a case of

Disease of the Aortic and Mitral Valves,

and exhibited the recent specimen. A man, aged 25, tall and powerfully made, a labourer, and in the habit of raising heavy weights, was admitted into the Whitworth Hospital on the 7th of November last, until six months previous to which date he had enjoyed uninterrupted health. When he was admitted, he presented a very anæmic appearance; his breathing was short and difficult, and he complained of great pain in the region of the heart; the dyspnœa occurred in paroxysms, and he had occasionally slight hæmoptysis. On examination, the existence of disease of the aortic valves with permanent patency, was discovered; there was a double murmur at the aortic orifice, visible pulsation of the carotids, and the pulse at the wrist presented the usual jerking characters; during the four days preceding the death of the patient, however, the pulse had lost this peculiarity; all the evidences of permanent patency of the aortic orifice, as originally described by Dr. Corrigan, existed in a marked degree. Upon examination after death, the pericardium was found to contain a considerable quantity of fluid, which was probably effused not long before the patient's death. The heart was nearly twice as large as natural, and the left ventricle was at least double its normal thickness. The aortic orifice, though permanently patent, merely admitted of the introduction of a full sized catheter, being obstructed by a copious deposition of atheromatous and calcareous matter, which covered both surfaces of the valves, and to some extent distended the sinuses. The left auriculo-ventricular orifice was slightly contracted, and its valves were thickened.

Dr. Banks alluded to the cases brought before the Society in 1845, by Dr. Law, of the co-existence of disease of the aortic and mitral valves, showing the effects on the form of the heart produced by the double lesion, the heart being elongated where the aortic valves only are diseased, but

where the mitral also are engaged, the organ assuming a more rounded form than in the other case. In the present instance, as in the cases detailed by Dr. Law, the chief seat of disease was at the aortic orifice. Dr. Banks observed that it was worthy of notice that the subject of this lesion of the heart had never been affected with acute rheumatism, to which in most instances of permanent patency occurring in early life, the organic affection is traceable.

In illustration of this fact, the following case was mentioned:—A young man, æt. 19, was lately under Dr. Banks' care in the Hardwicke Hospital, labouring under acute rheumatism. On his admission, and for many days, the heart remained free, the sounds, &c., being perfectly normal; subsequently pericarditis, followed by endocarditis supervened, and for a considerable time, indeed until he left the Hospital, he presented the characters of aortic patency, in a well-marked form. It was most interesting to see the disease develop itself under our actual observation.

Dr. McDowall exhibited the recent specimen in the

Case of Pericardial and Endocardial Disease, to which he refers at page 2, of our present number.

At the meeting held on December 13th,
The President, DR. CORRIGAN, in the Chair.

DR. MAYNE exhibited a specimen of

Cancer of the Lung

in a woman 45 years of age, which had existed for fifteen months. The contracted state of the affected side gave rise to considerable difficulty in the diagnosis. The full particulars of this very interesting case will be published in our next number.

Dr. BARTON presented a specimen of

Simple Organic Stricture of the Pylorus.

The case was that of a man, aged 40, who was admitted into the Hospital of the North Union Workhouse in June last, complaining of daily sickness of stomach, and vomiting after his meals. His countenance, naturally florid, was greatly wasted, and his whole body emaciated. The lower part of the abdomen was shrunken and retracted, while the left hypochondriac and epigastric regions were prominent and very tympanitic upon percussion. No tumour could at first be discovered. He vomited regularly every day about two hours after breakfast, the ejected matter consisted of the meal last taken, and other partially digested matter. The bowels were costive, the action of the heart was very feeble, the skin dry and rough. He could give no account of his illness; he had been a healthy labouring man, until about six months before his admission, when he began to suffer from sickness of stomach, since

which time he had been rapidly getting weaker. The bowels were freed by enemata, and the system supported by a liberal allowance of nourishment and stimulants; besides which a great variety of treatment was put in requisition to check the vomiting, without, however, any permanent good effect. He got weaker daily, plainly from want of nourishment, as almost everything taken into the stomach was vomited. Towards the end of July, a tumour was for the first time discovered in the right hypochondrium, about the size of the shut fist. Next day the whole of the anterior part of the abdomen and thorax was covered with petechial spots, such as appear in a bad form of typhus fever; his pulse was scarcely to be felt; he died next day.

The body was emaciated to a great degree; the lungs were healthy, but pale and exsanguineous, like those of an animal bled to death; the heart was small, and in the cavity of the pericardium there was about three ounces of a deep red serum; upon laying open the abdomen, the stomach was found to occupy the right and left hypochondriac and epigastric regions, as far down as the umbilicus. Just at the commencement of the first portion of the duodenum a hard tumour existed about the size of a walnut, about half an inch in length, quite smooth externally. The rest of the intestinal tract was healthy, and quite empty. Upon laying open the enormously distended stomach, about two quarts of a dark fluid, the colour of coffee grounds, was poured out; the mucous membrane of the stomach was very pale and soft; no rugæ existed. Close to the pyloric extremity, upon the anterior wall, was the oval cicatrix of an ulcer; the finger passed into the pylorus, met with an obstruction close to the orifice; the tip of the little finger could, with some force, be thrust through this ring-like stricture, by which it was firmly grasped. The liver was small, blue, and shrivelled. Dr. Barton called the attention of the Society to the circumscribed local nature of the disease, as it did not occupy more than about a third of the first portion of the duodenum; the presence of the cicatrix of an ulcer close to the stricture was interesting, as suggesting that the origin of the latter was coincident with cicatrization of the ulcer, lymph being effused into the submucous tissue around the pylorus, became organized and finally contracted. With regard to the diagnosis of the simple organic stricture of the pylorus, Dr. O'Ferrall had, several years ago, brought under the notice of the Society, a case very similar to this, in which he pointed out the difference in the symptoms produced by simple organic stricture and cancerous disease of the pylorus, as follows:—in the cancerous disease the countenance is bloated and pasty, the food passes rapidly through the intestines, diarrhoea is present, and death takes place from the extension of malignant disease to other organs. While in the simple organic disease, the countenance has a remarkably

wasted, starved look; there is vomiting; the bowels are constipated, and death takes place from inanition. These observations of Dr. O'Ferrall were well borne out by the case then before the Society.

Since this specimen was laid before the Society, a thin section of the indurated tissue forming the stricture was examined under the microscope, and found to consist almost entirely of dense fibrous tissue.

Gangrenous Abscess of the Larynx as a sequela of Fever.

Dr. FLEMING presented a specimen of laryngeal disease, the interest attachable to which arose from the fact of its sudden supervention in the convalescent stage of the ordinary typhus of the country. The subject of it was a boy aged 15 years. His fever was of the most aggravated character, the prominent symptoms being mainly cerebro-spinal and pulmonary. In the third week convalescence was fairly established, when suddenly dyspnoea and orthopnoea, accompanied with the characteristic signs of croup, supervened, and in less than three days death took place. Dr. Power, Professor of Anatomy in the Royal College of Surgeons, witnessed this case at the most critical stage of the feverish symptoms, and at the most aggravated of the laryngeal. The specimen is instructive as illustrating the serious nature of such contingency, and the rapidity with which such a large amount of disease can be established. It was remarked that the voice was unaffected in this case, and that the croupy, barking cough and peculiarity of respiration in croup were very marked. The abscess was below the rima. The sinus was normal. The locality of the morbid lesion was at the base of the cricoid cartilage, and implicated the arytenoid cartilages and their articulation, so that they could almost be completely enucleated. The trachea and bronchi were highly inflamed, and although no plastic effusion could be said to be present, yet a sort of creamy exudation lay on the surface, which, when scraped off, left the membrane underneath intensely vascular. Dr. Fleming remarked that he had casually looked into Rokitansky on the Abnormal Condition of the Respiratory Organs, and that he found he alluded to "the typhous process on the mucous membrane of the air passages," and specially noted that of "laryngo-typhus," of which disease Dr. Fleming was disposed to consider this specimen somewhat illustrative. He mentioned a case which occurred in Stevens' Hospital, whilst he had the charge of the fever wards, under Sir Henry Marsh, in one of the late epidemics, and noted the age of the boy, the convalescent stage in the period of attack, the suddenness of supervention, and rapidity of fatal termination, as bearing a strong resemblance to the case now given. The disease, however, in this case was genuine croup, "the exudating process yielding a plastic fibrous

product," which coated the larynx, the trachea, and the bronchi, to the extreme terminal branches. Here the case could not be said to be croup; it was not laryngeal phthisis; it was not syphilitic laryngitis; and the question was, was it a species of Laryngo-typhus?

SURGICAL SOCIETY OF IRELAND.

The first meeting of this Society for the Session 1856-7 was held at the College of Surgeons, on Saturday evening, December 13,

Dr. BEATTY in the Chair.

The President, Dr. WILLIAMS, being absent from illness, the usual opening address was not delivered.

Mr. BUTCHER, after referring briefly to his interesting memoir on *Excision of the Knee Joint*, published in vol. xix. of the *Dublin Quarterly Journal of Medical Science*, and in particular to the case operated on by himself, said he was anxious to submit to the Surgical Society of Ireland the progress of this important case, from the period of the original narrative, February, 1855, to the present time. The operation was performed on the 20th of January, 1854, for incurable disease of the left knee-joint, so that nearly three years had now elapsed; and Mr. Butcher now submitted the patient for accurate examination as to the powers and condition of the limb. He is about 36 years of age, a shoemaker, strong and healthy looking, and appears to have most perfect use of the leg. He can walk long distances without fatigue, and his lameness is scarcely observable. The necessary shortening at the knee-joint is in a great measure compensated for by the drooping of the pelvis on the left side.

Mr. Butcher next detailed a very interesting case of burn of the leg, and exhibited a cast which illustrated admirably the immense amount of contraction which was caused by the extension of the cicatrix into the popliteal space. The removal of the leg was necessary, to enable the patient to follow any employment, but Mr. Butcher contrived that this should be performed without the removal of the knee-joint, which to a superficial observer would appear impossible. The result of the operation proved not merely the possibility, but the advisability of such a proceeding.

Dr. POWER read a paper on the "*Effects of Tartar Emetic upon the Muscular System while spasmodically affected by Strychnine*." He founded his observations principally upon a case which occurred several years ago under the care of Dr. Hutton, in the Richmond Hospital, and the particulars of which he detailed. Strychnia was given in very small doses to a young female, for a paralytic affection of the arms, until symptoms of poisoning were produced; these were combated, among other means, by the exhibition of tartar emetic, by which they were subdued repeatedly,

having recurred again and again, after two or three long intermissions. Dr. Power conjectured that Palmer endeavoured by means of tartar emetic, firstly, to induce a condition of sickness in his victim, and secondly, to disguise the pathognomonic symptoms of poisoning by strychnine to be afterwards administered.

After some very interesting observations by Dr. CARTE and Professor GEOHEGAN, the Society adjourned.

ABSTRACT OF THE PROCEEDINGS OF THE BELFAST CLINICAL AND PATHOLOGICAL SOCIETY.

November 22nd.

The PRESIDENT in the Chair.

DR. PIRRIE placed before the Society a very interesting

Specimen of Hypertrophied Heart,

weighing 21 oz., the normal weight being about 8 oz. The patient, Martha Clarke, aged 57 years, a cook, was first admitted into Frederick-street hospital in December, 1855, suffering from hæmoptysis, at that time supposed to be connected with hypertrophy of the heart. She was again admitted in July, 1856, labouring under dyspnoea, with thirst, sickness of stomach, and great debility. The points of middle and little finger were gangrenous, the radial artery was enlarged and tortuous, its pulsations were visible; there was considerable dulness over the cardiac region; the heart's action was increased in force, but not in frequency, no valvular murmur, or other evidence of disease of valves, the sounds were loud and distinct; no dropsy. The gangrene extended until it engaged the hand, the lungs became very much congested, dyspnoea urgent, and patient died rather suddenly, on November 22nd, 1856. No history of any rheumatic attack could be traced. Dr. Murney, who made the *post mortem* examination, stated that the heart weighed 21 oz., that the valves were healthy, that no trace of atheromatous deposit could be detected on the coats of the aorta, brachial, or upper parts of radial or ulnar arteries. The right hand was injected from both radial and ulnar vessels. On dissection, the digital trunk for the supply of the ulnar side of the little finger was found much smaller than usual, that which supplied the radial border of the same finger was a good deal larger than natural, so that we might infer an ample supply of blood could be received from the single trunk, even suppose the small vessels were obliterated. He considered there were no evidences of arteritis, and that we must attribute the affection to a debilitated condition of the part, which, when subjected to inflammatory action, was unable to pass through the grades of that process, but immediately perished.

DR. YOUNG read a

Case of Obstruction of the Bowels.

M. D., a farmer, was a martyr to constipated bowels, for which he was in the habit of dosing himself with blue pill, salts, and senna; he was occasionally subject to slight pain in the descending colon; and a severe attack, which resisted the usual remedies, was the cause of Dr. Young's being sent for. There was neither constitutional irritation, nor pain on pressure, nor any evidence of a tumour. The symptoms were relieved by a dose of castor oil, combined with antispasmodics; the medicine did not affect the bowels, which had not been opened for 24 hours. The following day the pain was as severe as before, the bowels being still confined. Enemata of oil and turpentine were administered, but were returned; and mercurial purges failed to produce any effect upon the bowels. Leeches were applied to the seat of pain; 12 hours elapsed, the pain became much more severe, and the whole of the affected region tender to the touch, pulse frequent, tongue foul, and urine passed every ten minutes; during a paroxysm some relief was afforded by using O'Beirne's tube, but the bowels were not moved, and in a little time his sufferings again were so intense, that his friends anticipated his death. The enema was repeated, leeches applied anteriorly, and a blister posteriorly, blue pill steadily continued, and anodynes administered. The urine was examined, and found healthy. Upon the fourth day there were some evacuations from the bowels, which were almost white, but no appearance of scybala or gall-stones. The paroxysms of pain now recurred at longer intervals, and were still confined to left side; being somewhat periodic in their recurrence, quinine was prescribed, in conjunction with opium. Great relief was obtained by putting the feet into warm water. In ten days the patient was convalescent; the obstruction here only lasted three and a half days; the bile did not appear in the stools for a week. Dr. Young regarded the case as one of spasmodic irritation of the colon, produced by the passage through the bowels of undigested food. The suppression of bile, he believed, was owing to the patient's injudicious system of stimulating the liver by blue pill and aperients, this being followed by a temporary suspension of its functions.

DR. SEATON REID thought gall-stones were the cause of the attack.

PROF. FERGUSON coincided in this opinion, adding, that not finding gall-stones in the evacuations is no proof of their absence.

DR. DILL related the history of a

Case of Internal Strangulation.

G. Mc'C., æt. 17, a stout healthy-looking ship-carpenter, was admitted into Frederick-street hospital, on the 17th September, for obstruction of the bowels. He was quite well until the evening of

the 11th, when he was seized with a severe pain in his bowels, shortly after having partaken, rather heartily, of a meal of potatoes. Vomiting commenced during the night, and continued at intervals until morning; he was then visited by Dr. James Smith, who found him with a pulse about 80, no fever, tongue coated with a thick white fur, very slight tenderness upon pressure over the abdomen, and not much distention. He ordered pills of colocynth and calomel, to be followed by a castor oil draught; turpentine-stupes to abdomen. Sep. 13th. Dr. S. found that the pills and draught had been rejected, the bowels were still unopened. Patient's state was much the same as yesterday. Pills of calomel and opium were prescribed, sinapisms over the abdomen, and the oil draught repeated. Sep. 14th. For a little the vomiting ceased after he had taken the pills, but it had returned, and the symptoms were rather aggravated. The abdomen was now becoming tympanitic, but not tender; expression anxious; pulse 80. The pills were continued, stupes applied, and enemata administered; these latter were returned, and the symptoms were unrelieved, and there being now little doubt but that some obstruction of the bowels, of an obscure but grave character, existed, he was sent to hospital, where a large blister was applied over the abdomen, and much the same plan of treatment followed as before admission. No relief was afforded, the vomiting continued, the abdomen became more distended, the pulse frequent and weak; and he died exhausted, upon Sep. 19th, the third day after admission into hospital, and the seventh of his illness. A *post mortem* examination was made a few hours after death, when the peritoneum was found very much congested, but no lymph or fluid effused, or other evidence of inflammation. The upper portion of the small intestine was greatly distended, and formed a striking contrast with the lower third, which was small, contracted, and had a dark congested appearance. Upon close examination, this portion was discovered to be tightly encircled by a band which entirely prevented the transit of the contents of the canal. This band was narrow, resembling very much a thin piece of omentum. It was attached above in the right hypochondrium, and after constricting the intestine was found tied down in the left iliac fossa. Such being the cause of the obstruction, it was evident no medicinal agents could have been of any avail.

DR. JAMES MOORE showed

Six Specimens of Urethral Calculi,

which he had removed upon different occasions. He referred to the history of the cases, and to the mode by which he effected their removal.

November 29th.

The PRESIDENT in the Chair.

Case of Apoplexy.

DR. DILL presented a brain removed from the body of a patient, A. B., aged 72 years, who was found lying insensible and collapsed at a late hour, being a night watchman. He was removed to hospital, where he remained in a state of complete unconsciousness for 36 hours. Under the use of stimulants, &c., &c., he gradually recovered his mental and physical powers. He continued to improve for six days, when coma suddenly supervened, and he died in six hours after. On examination, 24 hours after death, a very large quantity of serum escaped from the arachnoid cavity; a large clot of blood was found lying upon the upper and posterior surface of the right hemisphere of the cerebrum. Extending from this point, anteriorly, there was a more superficial extravasation, as seen in the specimen. An animated discussion followed, in regard to the propriety of bleeding in cases of apoplexy, the opinion of the majority of the Society being, that at present such practice should be adopted with great caution, and in very few cases.

The Secretary read a paper communicated by Mr. GRAHAM (Templepatrick), upon a

Case of Anasarca and Puerperal Convulsions, terminating fatally before delivery.

March 20th, 1855, Dr. Graham visited Mrs. A., æt. 22 years. She was then in the end of the eighth month of uterogestation, being her first pregnancy. She had enjoyed very good health until about two months before being seen by Dr. G.; at that time her feet and limbs began to swell, and now there was anasarca of the entire body. The eyelids were so distended, that she was unable to open them. For two weeks past she had been much annoyed with headache, and the bowels were constipated. The urine was secreted in very small quantity, and upon being tested afforded no evidence of albumen. She was treated with diuretics and purgatives, and there was a decided improvement in her symptoms until the morning of the 27th, when Dr. G. was called to see her, as she had been seized with "a fit." He found her seated at the fire, complaining of severe headache, and rather incoherent. He bled her freely, after which she expressed herself relieved. The hair was cut, cold water constantly applied to the head, and a draught of castor-oil and turpentine administered. At this period the movements of the child were strong, and the fœtal pulsations distinct, but on examination there was no evidence of labour having commenced. Dr. G. saw her again at three o'clock, p.m.; she had five attacks during his absence, and was now unconscious. He bled her again, but not so freely, after which she answered questions that were put to her. An enema was administered, which acted satisfactorily.

There was great restlessness and tossing, and the tongue had been very much lacerated. In a little time another strong convulsive attack occurred, in which she died. The child was alive for some minutes after the respiration and circulation of the mother had ceased, but no interference would be permitted. Dr. FERGUSON did not think that this case could come properly under the category of puerperal convulsions. He considered it one of albuminuria; and he wished to draw attention to the fact, that towards the close of such cases it often happened that the albumen disappeared, neither heat nor nitric acid affording any evidence of its presence. The sp. gr., however, continued low, and he attached much weight to this.

Dr. BICK read a paper on a

Case of Puerperal Convulsions.

March 7th, 1856, he was called to visit M. M. C., æt. 20 years. He was informed that she had dropsy, and had been working in convulsions for 16 hours. He found his patient to be a muscular, stout woman. She was strongly convulsed; her face was gorged with blood, and her features distorted. Her lower extremities were enormously swollen; the abdomen was larger than usual at the full time of gestation. She was unmarried, and having concealed the fact of her pregnancy, had been under treatment for "dropsy" for two months past; and even since the convulsive seizure, a blister had been applied to the nape of neck. Dr. B. suspecting that there was an eccentric cause, at once proceeded to make a vaginal examination, and was not surprised to discover a soft os-uteri, pretty well dilated, with the membranes tense and projecting. He bled her to about 30oz., and ruptured the membranes: in a few minutes she was delivered of a male child of about eight months. On again examining, he found a second bag of waters, which being ruptured, the feet of a second foetus came into his hand. This passed easily; both were dead. The convulsions had now ceased, but she was comatose. A large dose of calomel was given, and the blister dressed with mercurial ointment. The convulsions did not return; the œdema disappeared; and in a few days she became quite sensible, but had no recollection of what had taken place.

December 6th.

The PRESIDENT in the Chair.

Case of Disease of Right Side of the Heart.

Dr. PIRRIE exhibited a heart removed from the body of Margaret Murphy, æt. 24 years, a sempstress, who was admitted into the General Hospital on the 28th of October. She had been ailing for about 10 days before admission, and was evidently labouring under an attack of acute rheumatism. She complained of pain in the cardiac region, and had some dyspnoea. At this time the affection of

the joints was not very acute. A loud bruit was heard, most audible at the base of the heart. From the history of the case, and other symptoms, Dr. P. inferred that there had been pre-existing heart-disease; however, shortly after her admission, an acute attack of endocarditis supervened, as evidenced by rational symptoms, and by a modification in the tone and intensity of the pre-existing abnormal sounds. Under treatment she gradually improved, and was considered convalescent, when a sudden attack of difficulty of breathing seized her, attended by great prostration, and followed by death, after six hours' agony, on 28th November, one month after admission. On making a *post mortem examination*, the right side of heart was found much distended with venous blood; there was considerable hypertrophy, with dilatation, especially of the right ventricle and pulmonary artery. The tricuspid and pulmonary semilunar valves were thickened, and covered with fibrous vegetations. The margins of the aortic semilunar valves were also roughened by fibrous deposit, but not to the same extent as the pulmonary and tricuspid. The mitral valves were smooth and perfect. Dr. P. considered that the interest of this case lay in the fact, that the right side of the heart was found to be the chief seat of disease, which we know is contrary to the general law.

Dr. SEATON READ referred to a case with which he had met some years since, and in which he believed the pulmonary semilunar valves to have been those solely affected. Under mercurialization the symptoms were removed, and the patient recovered.

Mr. HARKIN read the following interesting history of a

Case of Cerebral Disease.

D. C., æt. 47 years, by profession an architect, had been suffering from general paralysis for several months before I saw him. The disease manifested itself at first by a *severe pain in the tongue*, for which, having been unsuccessful in obtaining relief in this town, he consulted Mr. COLLES. That gentleman immediately pronounced the ailment as a symptom of incipient cerebral disease, and described to his ordinary medical attendant the future symptoms most accurately, just as they afterwards occurred, terminating at length in mental aberration, paralysis, and death. The first symptom of derangement which he exhibited happened while superintending the erection of the savings bank in Waterford, several of his Belfast friends having been favoured every week, for some time, by a present through the post of "hat almanacs;" and this circumstance led his friends to pay more attention to his state, and finally to put him under strict surveillance. His symptoms gradually increased: constant headache, occasional epileptic attacks, paralysis of upper and lower extremities, loss of hearing, of voice, &c.; ending in complete mental imbecility. When I first saw him, he had

been ill for 18 months; all his senses absent but those of touch and vision. He uttered piteous moans when any one approached him, was suffering from bed-sores which he could not bear to have examined, voided all his evacuations involuntarily, and died at last in a complete state of marasmus. On removing the cranium, a few hours after death, the dura mater was found attached to it in several places by bony deposits, particularly in the vicinity of the frontal eminences; their shape was circular, and their diameter about an inch in extent. The arachnoid appeared much thickened, and was separated from the pia mater, throughout its whole extent, by serum and coagulated lymph. The substance of the brain was flabby, and much softer than natural, and the distinctions between the cortical and medullary substances almost entirely obliterated. The spinal marrow was very much reduced in size, but firm. The serous fluid measured fully 12 ozs., and had penetrated between every convolution of the cerebrum and cerebellum, extending even to the spinal canal. The ventricles were quite distended with serum, communicating with the general mass of effused fluid through the infundibulum. The inner surface of the ventricles was highly vascular, and the corpora fimbriata were studded over with small hydated-looking vesicles. The nerves and their origins appeared in a perfectly normal condition, with the exception of the fifth of the right side, which was considerably wasted and softened. The basilar and other arteries were unusually developed, and contained numerous coagula, but whether cadaveric or not was not apparent. There was great engorgement and congestion of all the vessels, more strongly marked in the vicinity of the pineal gland and corpora quadrigemina. There was not any opportunity afforded of weighing the brain.

Bibliography.

The Medical Profession in Ancient Times: an Anniversary Discourse delivered before the New York Academy of Medicine. By JOHN WATSON, M.D., Surgeon to the New York Hospital. 1856.

We can recommend this address, as one of the best resués of the state of medicine in ancient times that has been yet written. Dr. Watson's name is already familiar to many of our readers as one of the most eminent surgeons of America, who has enriched surgery with many practical essays of great value, and who has been foremost among those who have perseveringly struggled to raise the profession in the United States, by extending the preliminary and professional education of the student of medicine. The present work was begun by the author at first for his own gratification, and to attain an insight into the state of medicine in ancient times. It gradually grew

to its present extent, but not without great labour and research, Dr. Watson not being content to take his materials from medical histories, but having gone to the fountain sources. This gives a freshness and original interest to the work. We think it is one that every medical man should possess, and we trust Dr. Watson will make some arrangement with an English bookseller, to render its possession attainable in this country. Our space forbids a systematic critique, or any attempt by extracts to convey an idea of the contents. A clear and interesting description is given of each of the great schools of medicine—Egyptian, Greek, and Roman, and the most celebrated writers, teachers, and practitioners that shed a lustre round them. We thus have short biographies of Hippocrates, Aristotle, Asclepiades, Celsus, and many others, with expositions of the various doctrines which divided the practitioners of old. A short extract—all we can give—may convey a faint impression of the interest of the book.

"The personal character of Galen," says Dr. Watson, "is seen in the numerous incidental allusions and amusing anecdotes scattered through his writings, some of which are of sufficient importance to be given in his own manner:—

"Soon after my arrival in Rome," says Galen, Glauco the philosopher took a great fancy to me, in consequence of my reputed skill in diagnosis. Meeting me accidentally in the street, and shaking hands with me, he remarked: I have fallen on you opportunely; I wish you to visit with me a patient in this neighbourhood, whom I have this moment left—the Sicilian physician, whom you saw walking with me some days since, and who is now ill. I inquired of him what ailed his friend, when, with his habitual candour, he replied, that Gorgias and Apelas had spoken to him of my skill in diagnosis and prognosis, which appeared to them more like the result of divine inspiration than of medical science, and that he wished to know for himself whether I was really thus skilful. He had hardly done speaking when we reached the door, so that I had no opportunity of replying to his request—as I have often said to you—that on some occasions the signs of disease are certain; at other times they are ambiguous, and require to be considered again and again. But as I entered, I observed a servant carrying from the sick chamber a vessel containing a thin bloody sanies, like the recent washings of flesh, a sure evidence of diseased liver. Without appearing to notice this circumstance, I proceeded with Glauco to the patient's apartment, when, placing my finger on the wrist of the sick man, I examined his pulse in order to determine whether the attack was inflammatory, or simply a weakness of the affected viscera. As the patient was himself a physician, he remarked that he had recently been up, and that the effort at rising might have accelerated the pulse; but I had already discovered the evidences of inflammation, and seeing in a recess in the window a jar contain-

ing something like a preparation of hyssop in honey and water, I knew that he had mistaken his disease for pleurisy, in which, as in inflammation of the liver, there is usually pain under the false ribs. He had been led to this opinion, as I at once perceived, by experiencing this pain, by his short breathing, and by a slight cough. Understanding the case, therefore, and turning to good account what fortune had thrown in my way, in order to give Glauco a high opinion of my ability, I placed my hands over the false ribs, on the right side of the patient, and at the same time declared this to be the seat of pain, which the sick man admitted to be correct. Glauco, supposing I had made this discovery merely by feeling the pulse, began to express surprise; but to increase his astonishment, I added: 'Inasmuch as you admit the existence of pain at this spot, I wish you further to say whether you are troubled with a slight cough, and whether your cough is not dry, without sputa, and occurring at long intervals.' While I was yet speaking, the sick man was seized with a cough such as I had described, whereat Glauco was exceedingly excited, and no longer able to contain himself, began to vociferate the praise of my abilities. 'Do not think,' said I, 'that these are all the discoveries my art enables me to make; there are others yet to be mentioned, which will elicit the testimony even of the patient.' Then turning to the latter, I resumed: 'Is not the pain in this part increased, and accompanied with a sense of weight in the right hypochondrium, whenever you take a full breath?' At hearing this the patient was also surprised, and was as loud in my praise as Glauco. Seeing fortune still smiling on me, I was desirous of making some remark in reference to the shoulder, which appeared to be drawn downwards, as often occurs in severe inflammations, as well as in induration of the liver; but I did not venture to speak on this point, fearing to diminish the admiration which I had already excited. Nevertheless I touched upon it cautiously, saying to the patient: 'You will not long feel the shoulder drawn downwards, if perchance you do not find it so already.' When he admitted this symptom also, seeing him greatly astonished, I said, 'I will add but one other word, to show what you conceive to be the nature of your complaint.' Glauco declared he would not be surprised if I should do even this; but the patient, overcome with wonder at such a promise, observed me closely, waiting for what I should say. I told him he had taken his disease to be a pleurisy. This, with a further expression of surprise, he admitted to have been his own opinion, as well as that of his attendant, who had been fomenting his side with oil for the relief of that disease. From this time forward Glauco entertained the highest opinion both of me and of our art; for having never before come in contact with a physician of consummate ability, he had hitherto formed but an humble estimate of the profession."

"Ist die heilkraft des Leberthranes so gross, wie man bisher angenommen? Mit besonderer Rücksicht auf Scrophulosis, Tuberculosis, und Rachitis, erörtert. VON DR. M. I. MARCUS."

Is the remedial power of Cod Liver Oil so great as has hitherto been supposed? Discussed with an especial regard to Scrophulosis, Tuberculosis, and Rachitis.

Such is the inquiry Dr. Marcus proposes. He first enters upon a disquisition on the chemical constitution of the *Oleum Jecoris Aselli*, and its component parts, which are believed to be energetic. Secondly, he considers the question of its efficacy or its want of efficacy, in rachitis, tuberculosis, and scrophulosis, and finally he speaks of the "surrogates," or substitutes for this oil which have been employed. When we reflect upon the various remedies which have, from time to time, been used in some of the diseases mentioned, especially in tuberculosis, we cannot fix upon any other which has taken its stand upon so firm a basis as Cod Liver Oil; and from the time when Professor Bennett, of Edinburgh, brought it prominently before the profession, the accumulated experience of practical physicians tends to strengthen our belief in its powers. A large experience has convinced us of its value, not alone in phthisis and the cognate affections, but in many other diseases; and we could add further proof of its efficacy in certain most intractable forms of cutaneous affections to that which we have already adduced. It appears to us rather late to question the exceeding power of this remedy in many and varied diseased states of the constitution. But as the object of the paper before us seems to be a meritorious one, we shall notice it, believing that in the minds of many there is a tendency to over-estimate the value of medicinal agents once their fame is established, and perhaps in no case is this more observed than with respect to Cod Liver Oil. We therefore think that to this class a few words may not be misapplied; the tendency being to remove the overweening confidence entertained in this agent, and to prevent its indiscriminate and empirical employment. We shall not enter upon the history of Cod Liver Oil, its rise and progress, and its well proved value; nor shall we refer to the first part of Dr. Marcus's paper, touching the analysis. To such as may need information on this and other matters concerning the oil, we beg to recommend a perusal of a review in the ninth volume of the *Dublin Quarterly Journal of Medical Science*, in which will be found an admirable resumé of the subject.

We pass to the second section of the paper by Dr. Marcus, in which the question of practical importance is discussed, viz., the "*vis medicatrix et non medicatrix*" of Cod Liver Oil.

Dr. M. says it would be foreign from his object to go over all the diseases in which this remedy has been administered, inasmuch as since it came

into use it has been considered a panacea for all, even for diseases of the most heterogeneous nature; he confines himself to a notice of its influence upon the three principal diseases in which it has been given—Rachitis, tuberculosis, and scrophulosis. The two latter are with intent submitted to a separate consideration, believing, with Lebert and others, in their independent existence. The power of the oil in rachitis is admitted, on the testimony of such distinguished practitioners as Bretonneau, Hauner, Mauthner, Canstatt, and others, and the words of Trousseau, physician to the "Hopital des Enfants Malades," in Paris, are quoted with approbation. According to Trousseau, the improvement is manifest in most cases of children whose stomachs can bear the oil, in from eight to ten days, and the bones become solid and firm after four, or at the utmost six weeks. The learned editor of the "*Journal für Kinderkrankheiten*" has not, however, observed this exceedingly rapid effect in rachitis.

Dr. Marcus informs us that his doubts of the efficacy of the oil were first awakened in the case of tuberculosis. Whilst some recommend the oil at the commencement of tuberculosis, with the view of prevention, others again affirm that its greatest efficacy is manifest in the second and third stage of phthisis. It has been noticed that an increase of weight by the continued use of the oil, even to the amount of from one to two pounds, each week, was not always coincident with a general improvement. The observations of Dr. Hutchison on a form of dyspepsia which occurs amongst the phthisical, and which is characterised by a difficulty of assimilating fat, are referred to. This complication clearly renders the use of this remedy inadmissible.

Dr. Vallon, in his report on the clinique of Professor Raimann, observes that the long continued use of Cod Liver Oil in some cases of tuberculosis, was productive of a favourable change; in other cases, through nausea, or weakness of the digestive organs, it could not be tolerated. And again, that in some instances, even after its protracted employment, no effect was produced. Dulk notices, amongst the effects which followed the use of the oil, an increase of the sweating, which is so distressing a symptom in phthisis. We must say that our experience is utterly at variance with this latter statement, for in the vast number of instances in which we have had recourse to the oil, in phthisis, we have never noticed an augmentation of the sweating fairly traceable to its administration.

After some further remarks on the use of the oil in phthisis, Dr. Marcus turns to scrophulosis. Dr. Hauner asserts that from frequent employment of Cod Liver Oil in the hospital for children at Munich, he has come to the conclusion that it has no especial power over scrophulosis. His experience, however, is different with regard to rachitis. Dr. H. has given up its use, finding it exerts an

injurious influence upon the digestive organs; children eat with less desire; their tongues become loaded; they suffer from nausea, eructations, and vomiting. It has also been noticed that the oil has passed away with the evacuations *undigested*.

Dr. Hauner remarks that the oil has been found less useful in the hot weather of summer than in the cool weather of winter. Schnitzer, a great panegyrist of Cod Liver Oil, admits that it has no absolute specific healing power as an antiscrophulous remedy. Dr. Manthner says he sometimes uses Cod Liver Oil, but he has no belief in its wonderful efficacy, finding it of little service. To obviate its indigestibility he gives it in the following form:

R: Ol. Jecor. Aselli
Muc. G. Arab.
Syr. cort. aurant aa ꝑss
Aqua Flor: Tilie ꝑi. m
3—4 teaspoons-full daily.

Dr. Marcus says that as a military medical officer his opportunities of seeing scrophulosis among the soldiers' children have been extensive, the condition in which they are placed being singularly conducive to the development of strumous disease. The quantity of oil used for these children has been enormous. Dr. M. employed it at first, but he became convinced of its inutility, and ceased to prescribe it. The conclusion which he has arrived at is, that Cod Liver Oil has most influence upon rachitis, next in order comes tuberculosis, and scrophulosis stands lowest in the scale.

Dr. Marcus finally makes some observations on certain succedaneous remedies, which have been tried in diseased states for which the oil is usually prescribed.

On the supposition that the value of the oil depends upon the fat, experiments have been instituted by Belgian physicians with animal and vegetable oils.

Trousseau reports favourably of the effect of fresh butter. Dr. Th. Thompson speaks well of the oil of cacao nuts; he has also used a mixture of almond oil and phosphorus.

Various preparations have been recommended as substitutes for cod-liver oil, in the belief of its possessing tonic qualities.

The leaves of the walnut tree have been highly praised by some French physicians. Iodine in combination with different kinds of oils, has been used as a substitute for cod-liver oil.

As a remedy for tuberculosis and scrophulosis, Dr. Mauthner has recommended the "*Extractum sanguinis bovini rec. preparatum*," which possesses the ingredients for the formation of blood, and is also of easy assimilation. It has been found useful for children whose stomachs could not retain even broth or milk. Other physicians have experienced similar good results. Mauthner gives it in doses of 10 grs., increasing the quantity to 1 oz.

Dr. Weisse, of St. Petersburg, has found a remedy nearly akin to the *extractum sanguinis*

bovini: viz., scraped raw beef, most beneficial in rachitis.

The object which Dr. Marcus has had in view in his paper is, to limit the excessive use, not to say abuse, of cod-liver oil, and to call the attention of physicians to like observations. We are ourselves unshaken in our faith in the great power of cod-liver oil—not merely as an internal, but also as an external remedy—over many forms of disease; but we have never looked upon it as a “universal remedy,” and have frequently had occasion to deprecate its inordinate and indiscriminate use.—*Journal für Kinderkrankheiten.*

Selections from British & Foreign Journals.

EMPLOYMENT OF TANNIN.—Dr. Berthel recommends the following treatment of chilblains: One ounce of bruised oak-galls should be boiled for an hour in two pounds of water, and the fluid, employed two or three times a day, forms a most efficacious application. The same result is obtainable by means of a decoction of oak-bark, or by a solution of half an ounce of tannic acid in gvi. of water. If no ulcerations are present, we may also employ tincture of galls. Tannin as a hæmostatic and styptic, inducing no irritation or pain, is of the greatest service. In gleety urethral discharges we may advantageously employ ss. of tannin dissolved in giv. of water, and combined with ss. of mucilage. The same mixture, taken by spoonfuls, internally, is very useful in chronic diarrhœa and commencing dysentery. In certain forms of chronic bronchitis the following formula has been of use, a spoonful being taken every second hour: Tannin, $4\frac{1}{2}$ grains; ext. bellad., 1 grain; ext. cicutæ, 3 grains; infus. sennæ, 3 ounces; aqu. feniculi, syr. althææ, of each 1 ounce. Mix. Tannin is also a very useful remedy in menorrhagia and leucorrhœa, but it requires to be taken in the pill form for months; and to prevent constipation it should be combined with aloes or rhubarb.—*Med. Zeit. No. 41.—Medical Times and Gazette.*

TREATMENT OF ITCH.—Dr. Schubert states that he always treats itch, both in private and hospital practice, by soft soap and salt. Eight ounces of the former and four of the latter are dissolved in a quart of water, the patient being well rubbed with the warm solution night and morning. It is rather a painful application, but a cure results in three or four days, and often sooner, except in very inveterate cases, when some more days are required. The skin is afterwards well cleansed in a bath, or with soap and water.—*Medicin. Zeitung, No. 28.—Medical Times and Gazette.*

EARL GRANVILLE has been appointed by the Crown, Chancellor of the University of London, in lieu of the Earl of Burlington, resigned.

NORTH LONDON OR UNIVERSITY COLLEGE HOSPITAL.—The Committee, at their meeting on Wednesday last, received notice of a legacy to the hospital of £5,000, free of duty, bequeathed by the late John Kenyon, Esq., of Devonshire-place. This gratifying communication was made to the committee by James Booth, Esq., and Robert Hawthorn, Esq., executors of Mr. Kenyon.

Correspondence.

NICOTINE versus STRYCHNINE.

To the Editor of the Dublin Hospital Gazette.

SIR,—In a late number of the *Gazette* there appeared a report of some interesting experiments made by Professor Haughton, upon the counter-acting effects of nicotine and strychnine. Would it not be well if some one who has time and opportunity would pursue the investigation, by giving a rabbit, for instance, a poisonous dose of strychnine, and then endeavouring to save him by nicotine, and having carefully repeated the experiment, let us know the result? I throw this out by way of hint to Professor Haughton, or any other investigator; for with us, over-wrought country practitioners, such investigations are out of the question; but I for one, would be most delighted to hear of nicotine being proved to be, in any measure, an antidote to strychnine. I am, &c.

C. P.

ISSUE-MAKING.

To the Editor of the Dublin Hospital Gazette.

SIR,—Can you or any of your numerous readers give me a receipt for making an issue, rapidly, surely, and with as little pain to the patient as possible? I am led to ask for this information from having found the *Potassa fusa* frequently so bad as to be quite inefficacious, besides inflicting great pain. I am, &c.

SUBSCRIBER.

COMMUNICATIONS have been received from Dr. Montgomery; Dr. Tucker (Sligo); Dr. Monahan; Belfast Clinical Society; Dr. Robinson (Ware), &c., &c.

NOTICE

TO SUBSCRIBERS AND CORRESPONDENTS.

The management of the Commercial Department of the DUBLIN HOSPITAL GAZETTE has been handed over to Messrs. BROWNE & NOLAN, 21, Nassau-street, Dublin, who will henceforth print and publish it; to whom all subscriptions are in future to be paid, and all communications for the Editor addressed.

Obituary.

DEATH OF DR. PARIS, THE PRESIDENT OF THE COLLEGE OF PHYSICIANS OF LONDON.—It is with sincere regret that we announce the death of this excellent and distinguished man. Few men have run so long and honourable a career. For half a century precisely Dr. Paris had practised as a physician, and had risen to the very highest honours which it was in the power of his professional brethren to bestow. He was born at Cambridge, on the 7th of August, in the year 1785. He became a member of Caius College, in that University, and graduated, when very young, in medicine. From Cambridge he went to Edinburgh, then remarkable as a school of medicine, and was the friend and intimate companion of the many celebrated men who, in the first years of the century, had congregated in the Scottish capital. On his return to London, at the age of 22, he was elected, as we before said, physician to the Westminster Hospital, but soon after vacated the appointment, as it was his wish to establish himself in the town of Penzance, in Cornwall. During his residence at Penzance Dr. Paris distinguished himself as the founder of the Royal Geological Society of Cornwall. This, we believe, was the first geological society in England. When at Penzance, too, he gave to the miners the great boon of the "tamping-bar," the instrument by which they are enabled to pursue their business amid inflammable gases, without the fear of striking fire from the rock. By this simple but admirable invention Dr. Paris no doubt saved more lives than many heroes have destroyed. In the year 1810 he returned to London, and here for forty-five or forty-six years he was actively occupied as a practising physician. He was elected President of the College of Physicians in the year 1844, and this office he held until the hour of his death. Dr. Paris was not only known as a physician of the highest eminence; he was as remarkable for his literary ability. The "Life of Sir Humphrey Davy" will ever remain one of the classical biographies of the English language. In conjunction with Mr. Fonblanque, he also wrote the "Medical Jurisprudence," which has remained a text-book with lawyers until our own day. His works of a more professional character were his treatise "On Diet," which first brought him into notice, and which was published at a very early age; his "Pharmacologia," which has run through more editions than most books; and his work on medical chemistry. Besides these, and many other acknowledged publications, his "Philosophy in Sport" has attained an enormous popularity, and with his life the motive for an incognito, which was never really maintained, has altogether terminated. The last ten days of Dr. Paris were spent in the midst of excruciating sufferings, which were borne with the most remarkable fortitude. His chief concern

seemed to be to console and comfort those around him, who could ill disguise their grief at the impending and irreparable loss. His intellect remained to the last as clear as at any time of his life; and while power of speech remained, nobody who listened to him could believe that the end was so near at hand.

JOSEPH LANGSTAFF, Esq., F.R.C.S., of the Hon. East India Company's Medical Service, died on the 6th inst., of apoplexy, in his 79th year, at his residence, 9, Cambridge-square. Mr. Langstaff obtained his commission in 1799, left for India the same year, and remained in the East until the end of 1839. During the forty years which he thus passed in active service in India, he proved a valuable and energetic public officer, and passed through all the grades of the medical service, terminating his public career as President of the Medical Board of Calcutta. In this lengthened period Mr. Langstaff took a part, as an esteemed and valued medical officer, in many of the important events which characterise Indian history during the first half of the present century. He was the medical attendant attached to Lord Metcalfe's embassy to Rungett Singh, from whom he personally received many evidences of esteem. He was also attached to the Marquis of Hastings' army, in the Maharatta campaign, in 1817, when the cholera made its first appearance. He retained to the last a vivid recollection of all the circumstances connected with the origin of this pestilence, which has since then devastated the universe. Mr. Langstaff returned to his native country in the possession of good health, and has lived many years to enjoy his hard-earned honours in the bosom of his family. At his death he was, we believe, the oldest medical officer of the Bengal Presidency.

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CASUAL OBSERVATIONS IN PRACTICE

By W. F. MONTGOMERY, M.D.,

Late Professor of Midwifery in the School of Physic in Ireland.

Last year, Professor Martin of Jena, and Herr Maier, wrote at some length "On the rising and falling of the pulse during labour." I have not had the advantage of seeing the original works, but from what I could collect from reviews and abstracts, I cannot find that they have discovered anything of much practical or physiological value. But I felt no small interest in such an investigation, owing to an observation which I first made several years ago, and which I have subsequently had several opportunities of repeating, but could never find in authors any allusion to the fact which had attracted my attention.

No. 1.—*Retardation of the Pulse after Labour.*

I have frequently observed in women, apparently in perfect health, that the day after labour the pulse was reduced from the ordinary rate of rapidity to 40, or between that and 50 beats in the minute; without any accompanying unfavorable symptoms of any kind; and from which state of retardation, it gradually rose from day to day, until it had regained the ordinary rate of pulsation.

The first time I observed this, was many years ago, when I had but little experience, and it alarmed me very much, as I feared it was the forerunner of convulsions, or some other untoward casualty, judging from what I had read in books.

1st Case.—This occurred in May, 1830, in a young and healthy woman in her first labour, which was so quick that she was delivered before I got to her, and in every respect the circumstances of her case were perfectly favorable; it was very warm summer weather, and she was a good deal heated from her labour, and her pulse quickened as is usual; but the next day, the pulse was only between 40 and 44, from which, it afterwards gradually rose to the natural standard.

2nd Case.—In this instance, the lady was after her first labour, which was favorable and easy,

though lasting for several hours; she had been, a year or two previously, suspected of a tendency to phthisis (of which some of her family had died), but was then well. The day after her labour, her pulse was only 40 at the most, and rose very slowly, so that at the end of a week, it was only 60, and was not restored to its natural standard of 80, for fully a fortnight. She was then, January 1842, and is still, in perfect health, and has since had six other children, and as before, her pulse, after each labour, sunk, but not so much, nor for so long a time; gradually rising about ten beats each day till it arrived at 80.

3rd Case.—The third instance was that of a young and very healthy lady, after giving birth to her second child, her labour having occupied about 12 hours, but being, in every respect, favorable; on the day after, her pulse sunk to 40, and was irregular, intermitting at every third or fourth beat; it gradually rose, and became regular, and her recovery was uninterrupted and complete.

I have seen many other examples of this occurrence, but those already related appear sufficient to embody its special characters.

I confess my inability to offer an explanation of this fact, but I wished to make it known, as occurring in cases uncomplicated with any unfavorable condition or result; in order that the young practitioner might carry it in his recollection, and not be led unnecessarily into the apprehension of danger, and the consequent adoption of treatment wholly unrequired.

No. 2.—*Curious phenomena regarding the Dilation and Contraction of the Iris.*

Oct. 20, 1845, I was called to see Mrs. M., at Glasnevin, who was deprived of the sight of her right eye so as not to be able to distinguish light from darkness, as she supposed by a recent and severe attack of erysipelas of the cheek and eyelids.

While examining the eye as to its sensibility to light, I observed that its pupil expanded when the face was turned away from the light, and con-

tracted, when the face was directed towards the light, both eyes being at the moment open: but I found that if I covered the left eye so as completely to exclude the light from it, the pupil of the right eye, although exposed to bright light at the moment, became quite dilated, as if in darkness; but immediately that I uncovered the left eye, so that the light fell on it, the pupil of the right eye (the blind one) instantly contracted, which it would not do if exposed alone to the light.

Hence it appears that the blind eye, although entirely insensible to the stimulus of light directly applied to itself, sympathized at once, and strongly, with the sound eye, the pupil contracting and expanding at the same instant in both.

Perhaps this observation is common and old; it was new to me.

No. 3.—Mental Impressions, or Presentiments of impending Danger, or approaching Death, verified by the result.

A case of this kind, of a very striking nature, having occurred to me, I am induced to record it, as possessing more than ordinary interest.

On the 6th of October, 1847, I was called to see a lady, whom I found labouring under cancer uteri; but of whose death, as near at hand, there was certainly no indication; her case was of course hopeless, but I thought she would live some months, at least.

Having given my opinion of the case, her husband begged that I would avoid, as far as possible, saying anything that might depress her, as, in addition to being naturally very nervous and easily alarmed, she had over her mind a strong feeling that something of a very serious, or dangerous, or fatal kind was to happen to her on the 28th of October.

I afterwards learned from herself that she was born on the 28th of October; that her first husband had died on the 28th of October; and that she had married her second husband on the 28th of October.

About the 20th of October it was observed that she was emaciating with extraordinary rapidity; she lost all relish for food; became from day to day, less capable of collecting her ideas, until Wednesday the 27th, when I was hastily summoned to her, and found the pulse beginning to fail, and the hands growing cold; and at 12 o'clock noon of the next day, the 28th October, she quietly resigned her spirit.

This case brought forcibly to my recollection another which I had seen about five years before.

At an early hour of the morning, I was requested to visit a lady, the mother of several children, and about forty years of age. I found her apparently much agitated and distressed; she told me that she felt unwell and very nervous, and attributed her agitation to a dream she had had, out of which she awoke crying.

She had dreamed that she was in a garden or churchyard, and looking at a handsome monument which some young children had erected to the memory of their mother; on looking at the children she had a confused idea that they were her own, and that the monument was for her, and bore, or was to bear, her name. She awoke in tears, felt greatly depressed, and apprehensive of something, she could not tell what.

I administered to her some composing medicine, and she became tranquil and fell asleep, but awoke much as before. After the most careful examination, I could not discover any evidence of disease of any kind about her. In the course of the day, she had two or three liquid discharges from the bowels, but no pain or other alarming symptoms, and towards evening I thought all cause of anxiety about her was over; but as night drew on, the uneasiness and depression returned, the pulse grew weak, and about 12 o'clock at night she breathed her last without a struggle.

Dr. Graves saw this lady with me.

No. 4.—Labour postponed for sixty-eight days after the Rupture of the Membranes.

A lady who had borne two children menstruated for the last time on the 22nd May, 1850, and then becoming pregnant, quickened on the 26th September, and went on perfectly well until the 11th November, when, just as she was going to bed, she became conscious that there was a watery discharge from the vagina, which, as the event proved, was the liquor amnii.

This occurred at her residence, between eighty and ninety miles from Dublin, and caused her great alarm, as she took for granted that her labour must be at hand, and as I had always attended her, she had a great objection to be confined under any other hands. So strong was this feeling, that she determined to run the risk of travelling up to town, which she did in a railway carriage, accompanied by a medical man, for fear of the worst.

She arrived safely in town on the 13th, and took up her abode near me; the discharge, which was generally limpid and colourless, but occasionally rose-coloured, continued without intermission; but it was soon observed, contrary to what might be expected, that the flow was greatest when the lady was lying down, and least, when she was sitting up, or walking about.

This, which she was the first to observe, puzzled her very much, and she pressed me for an explanation, which I did not feel much difficulty in offering, and I told her that I thought the opening, which I presumed was very small, had in all probability taken place very high up, while the lower part of the membranes remained sound; in which case, when she stood up, the water would sink below the level of the aperture, and so, not flow out, but when she lay horizontal, there was nothing

to prevent its constant escape: the result justified this supposition.

Her health continued very good, she drove or walked every day, she continued to increase in size, and the motions of the child were, to the last, active.

On the 18th January, 1851, labour supervened, and was short, and in every respect most favourable. On my arrival, I found a full bag of waters presenting at the os uteri, which was fully dilated, and in about an hour, she gave birth to a son, of full size, for eight months, but very white, and he never became rosy, as he ought, after crying strongly, which he did at first, but afterwards he fell into the peculiar incessant wailing low cry, which is always of such evil augury in new-born infants. A wet-nurse was immediately provided, but the child would not suck, nor would it swallow fluids conveyed into its mouth; it gradually grew more feeble and exhausted, and in six hours ceased to exist.

The placenta was allowed to come away with the least possible assistance, and on floating it in clean water, with its membranes, I found in the latter, within half an inch of the edge of the placenta, a small aperture of about an eighth of an inch in diameter, the edges of which looked as clean cut as if it had been made with a fine punch; this fully explained the peculiarity above alluded to.

Now, in this case, the daily discharge amounted, on an average, to about five ounces of fluid, and lasted for 68 days, so that there must have come away about 340 ounces, or 21 pints, making nearly three gallons; and it seems reasonable to infer, that the debility of the child arose from so much of the vital action which should have contributed to its sanguineous support, having been expended in secreting such a quantity of liquor amnii.

Such a lesion as this is also interesting, as affording a probable explanation of the nature of at least some of those cases, in which, abundant serous discharge takes place from the vagina during pregnancy.

I may mention as a curious fact, connected with this case, that the same accident happened to the lady's mother.

No. 5.—*Inversion of the Uterus.*

In the DUBLIN HOSPITAL GAZETTE, (*vide* vol. iii. p. 65,) I related the remarkable case of Mrs. M., who, in 1854, sustained complete inversion of the uterus, at the time of labour, with unusual freedom from the severe symptoms which generally accompany so formidable an accident. I have now to mention, that she was again confined last year, and had a perfectly favourable labour, without any tendency to a re-currence of the former displacement.

6th January, 1857.

ON CANCER OF THE LUNG.

By ROBERT MAYNE, M.B.,

Lecturer on Practice of Physic, Carmichael School of Medicine; and Physician to the Hospitals of the South Dublin Union Workhouse.

Notwithstanding the great advances which physical diagnosis has made of late years, Cancer of the Lung must still be considered one of the most obscure, as it certainly is one of the rarest diseases of the chest. Its very rarity is probably the cause of the great uncertainty surrounding its diagnosis, no single physician, how extensive soever his opportunities may be, seeing more than a very limited number of cases.

Dr. Hughes of London* has added something to the previous stock of knowledge in this department.

Dr. Stokes has laboured much, and successfully too, in the same field; indeed, to the principles so ably laid down by him, in his paper in the twenty-first volume of the *Dublin Journal of Medical Science*; (former series,) I am chiefly indebted for making a successful diagnosis in one of the following cases.

Dr. Gordon† has also contributed a valuable paper on malignant disease of the lung, and in many respects the case which he has published bears a striking resemblance to one of those hereafter detailed.

Feeling convinced that should certainty ever be attained in the discrimination of these diseases, it can only be expected as the result of the observations of many different contributors, I am induced to publish the particulars of the following cases, which have recently fallen under my own observation.

Catherine Breen, *æt.* 45, a married woman with several children, of whom the youngest is now about 10 years of age, earned her livelihood as a scourer. She had never suffered from uterine disease, nor from any affection of either breast. Her health, which had formerly been excellent, began for the first time to fail about the month of September, 1855, and in the month of September, 1856, she was compelled by her sufferings to enter the hospital of the South Dublin Union Workhouse.

Her earliest symptoms had been thoracic pains, which used to shoot from the sternum to the spine, and along the ribs and intercostal spaces of the right side, "like stitches." At first these pains were not very severe nor very constant, but by degrees they increased both in severity and in constancy, until at length they became almost intolerable; and it may be stated, that from the very first day of her illness to her death, *thoracic pains* constituted her most prominent symptom.

Soon after the pains set in, she began to cough; like the pains, the cough was at first slight and

* *Guy's Hospital Reports*, October, 1851.

† See *Dublin Hospital Gazette*, 6th September, 1856.

unfrequent, but by degrees it increased in frequency and severity; it was a dry cough, or nearly so, the expectoration being scanty throughout.

In addition to the pains and the cough, her breathing, at an early period of her illness, became short and difficult; like the other two symptoms, the dyspnoea crept on gradually; for many months it was not sufficiently urgent to disable her from working, but at length her sufferings from pain, and from cough, and from dyspnoea, became insupportable, and compelled her to relinquish her employment and to seek for hospital relief. It is a very remarkable circumstance in this woman's history, however, that for an entire year she bore up against her aggravated sufferings, and that the very day before her admission into hospital she was actually working for hire as a charwoman.

Soon after her admission into hospital I saw this woman, with my friend, Dr. Shannon, whose patient she was, and we were both of us struck with the following particulars.

There was great emaciation; her body was much wasted, and her face was not only attenuated, but deeply expressive of long-continued suffering. When we came to inquire about her general symptoms, we found that this emaciation was not the result of any profuse evacuations; for she never sweated, her expectoration was scanty in the extreme, and to the very day of her death, her bowels inclined to constipation, requiring the constant employment of purgatives; her appetite, too, never forsook her; for she consumed a fair allowance of food daily to the very close of her life.

Extreme emaciation, *without* diarrhoea, *without* sweating, *without* much impairment of appetite, and almost *without* expectoration, struck us as being unusual in chronic disease of the lung!

At some former period of her life she must have suffered severely from scrofulous disease of the cervical glands, for her neck exhibited numerous cicatrices of scrofulous abscesses, upon the history of which, however, she was unable to give any very satisfactory account.

On proceeding to institute a stethoscopic examination of the chest, the eye at once detected a remarkable difference in the shape and dimensions of the two sides of the thorax respectively. The *right* side was much contracted in all its measurements. In girth it was about three quarters of an inch less than the left. Viewed from before, the ribs at the *right* side seemed unduly approximated to each other; the *right* shoulder seemed slightly inclined downwards and forwards, and the vertical height of the *right* side of the chest seemed less than that of the left side. Viewed posteriorly, the contraction of the *right* side of the chest was also apparent, but less so than in front; besides the intercostal spaces at the *right* side appeared deeply depressed, yet the corresponding ribs moved much less freely in respiration than those of the left side.

Percussion showed a still more marked difference between the two sides of the chest respec-

tively. The *right* side, wherever struck, but more particularly in front, yielded a sound dull to the utmost conceivable degree, and from the sensation communicated to the fingers it also appeared to be totally devoid of elasticity. So marked were the dullness and the want of elasticity of the *right* side, that it might be compared to a thorax filled with molten lead. The left side of the chest was, on the contrary, everywhere clear and elastic when percussed.

The auscultatory phenomena at the two sides of the chest presented an equal contrast. Over nearly the entire of the *right* lung the respiration was loudly bronchial, in the right mammary region alone it was rather obscure, but even there too its characters were bronchial; whilst at every portion of the left lung the respiratory murmur was vesicular, preternaturally clear, and in fact supplemental.

There was but little evidence of bronchitis anywhere; no where could we detect either fine crepitus or muco-crepitus; here and there over the *right* side, and *over the right side only*, either sonorous or large mucous bronchial rales might be occasionally heard, but these were too transient to denote serious mischief of the mucous membrane.

Over the *right* side of the chest the sounds of the heart were transmitted to a very considerable distance, but there was no evidence of displacement of this organ, for its impulse was to be seen and felt to the left of the sternum as usual.

We were unable to satisfy ourselves that there was any marked difference in the intensity of the vocal resonance at opposite sides of the chest.

Most of the veins tributary to the superior cava were in a state of marked congestion, the superficial jugular veins in particular appeared large and turgid, and so did the superficial veins upon the front of the chest, *those at the left side of the sternum equally with those at the right side of the sternum*; but the tributaries of the inferior cava presented no such turgidity.

It would appear that this woman never had hæmoptysis, at least so she told us, but during the last month of her life she expectorated daily some gelatinous looking mucus, of a slate colour, and in quantity scarcely sufficient to cover the bottom of the spitting cup.

Up to the period of this woman's death her symptoms presented no very marked changes. The cough, the dyspnoea, the pains, became all more and more distressing, absolute orthopnoea supervened, her emaciation became extreme, and she sunk at length on the 8th of December, apparently from sheer exhaustion.

This case, from its unusual characters, made us hesitate a good deal at first as to our diagnosis.

The severe thoracic pains, like stitches, which had been an early symptom, coupled with the subsequently contracted side, led us for a moment to entertain the notion of its being an old pleurisy, with complete absorption of the effusion; but this

hypothesis was soon abandoned, because we were unable to trace the disease to an acute inflammatory attack, and because the disease had run a course progressively "worse and worse," whereas the very reverse should have been its course, viz., "better and better," had it really been a cured pleurisy.

Cirrhosis of the lung, so well described by Dr. Corrigan, might have caused many of the physical signs which this disease presented, such as the contracted side, the dull percussion sound, the tubular breathing, &c., but as we had never known cirrhosis of the lung to run its course without great mucous irritation, commonly continuing over a number of years, attended with abundant expectoration, and with corresponding stethoscopic signs, such as loud mucous rales, or even doubtful gurgillement, we soon concluded that cirrhosis was not the disease with which we had to contend.

Extensive tubercular deposit in the right lung, causing atrophy of the lung, might possibly have caused the contracted side and the dull percussion sound, and at first, the scrofulous cicatrices in the neck seemed to countenance this conjecture; but then such an extensive tubercular deposit would scarcely have continued in the crude state for *fifteen months*, without softening at a single point, without implicating the other lung, and without producing a single symptom of phthisical hectic; the notion of phthisis was therefore early abandoned.

An aneurismal tumour compressing the right bronchus might undoubtedly have produced a contracted side; indeed a case of the sort, attended by most distressing thoracic pains, and producing a great amount of deformity in the left side of the chest from the pressure of an aneurism on the left bronchus, was exhibited to the Pathological Society by myself about three years ago; but to bear out that supposition, the percussion sounds should have been clear over the whole superficies of the lung, whereas, the direct contrary was really the fact; and there ought to have been a second centre of pulsation apart from the heart; but of this no vestige was to be found. The idea of the disease being an aneurism was therefore no sooner entertained than rejected.

Finally, we thought that malignant disease of the right lung could alone occasion all the symptoms, taken both in the aggregate and in their order of succession; and this diagnosis was accordingly made with some confidence.

The *post mortem* examination fully verified our diagnosis. The left lung was found absolutely healthy. There was great difficulty experienced in eviscerating the right side of the chest, so enormously thick was the right pleura, and so firmly united to each other were its visceral and parietal layers. Removed from the chest, the right lung appeared remarkably reduced in volume; it was also remarkably firm and resisting to the feel, and had undergone a very extensive carcinomatous

transformation. To the scalpel it offered great resistance, cutting like cartilage. Its section exhibited a large admixture of true scirrhus with the proper pulmonary tissue. The scirrhus material was of a milk-white hue, hard as cartilage, and contrasted very remarkably with the blue colour of what remained of the original lung. The scirrhus deposit was in greatest abundance near the root of the lung, but no part of the lung was free from it. The bronchial tubes remained for the most part permeable, transmitting readily a probe through their cut orifices into the right bronchus. The section of the lung was perfectly dry, presenting no trace of œdema, nor of sanguinous congestion, and it was even remarked that the cut extremities of the bronchial tubes contained an unusually small amount of secretion.

There was in the mediastinum also a large scirrhus mass, consisting of a material identical in structure and appearance with that which so extensively pervaded the lung. The mediastinal tumour was inseparably identified with the right mediastinal pleura, *and through the very centre of this mass the superior vena cava descended*, to reach the right auricle of the heart; in transitu, this great venous trunk was greatly compressed, and to this cause may doubtless be attributed the marked congestions of its tributaries in the neck and elsewhere, which had so prominently attracted our attention during life.

All the abdominal and pelvic viscera were examined, but without revealing a trace of malignant deposit.

The diagnosis in this case rested partly on negative and partly on positive grounds.

There was a contracted side, but this contraction was not the result of pleuritis, nor of cirrhosis, nor of phthisis, nor of aneurism.

The woman's age was 44.

The disease had lasted exactly 15 months.

Severe thoracic pains, gradually progressive and never attended by fever; progressive emaciation, without sweating, without diarrhoea, and almost without expectoration; scanty, slate-coloured, gelatinous-looking sputa; enlarged thoracic and cervical veins; constant cough; extreme dyspnoea, and an amount of dulness and inelasticity of the side to which I had never before seen a parallel, were the prominent signs and symptoms.

Second Case.—Mary Joy, æt. 58, had been married for many years. In early life she had had two children. Her occupation was that of a sempstress, and her health had been excellent until about six weeks before her admission into the hospital of the South Dublin Union Workhouse, on the 20th of July, 1856.

Early in the month of June (as well as her recollection served) she had been seized with severe thoracic pains, shooting "like stitches" from the back of the right scapula through to the sternum; her breathing became gradually short and difficult, her strength became greatly impaired, and she be-

gan to cough. Notwithstanding these symptoms, however, she struggled on without medical advice, and it was only when the dyspnoea became suddenly so extreme as to threaten suffocation, and to prevent her altogether from lying down, that she sought admission into hospital.

When first seen in hospital she was sitting up in bed, a perfect picture of the most intense dyspnoea. She had a short dry cough, her speech was interrupted, her countenance was anxious, her lips were blue, her face was livid, the jugular veins were congested, and altogether suffocation appeared imminent; yet there was no anasarca or other indication of general dropsy.

On careful exploration of the chest, evidence of extensive effusion into the right pleura was discovered. On percussion, the right side of the chest was dull over its entire extent, even up to the clavicle, and the dulness was of the most marked description. On accurate measurement, the right side of the chest exceeded the left in girth by at least three quarters of an inch, and there was no œdema whatever to render this comparative measurement fallacious. There were unmistakable indications of eccentric pressure too, in a depressed liver and a displaced heart; the thin edge of the liver being felt distinctly more than three inches below the margin of the thorax, and the pulsation of the heart being both seen and felt far to the left of its normal position, indeed near to the left axilla.

The ribs at the right side, although not absolutely motionless, yet moved much less freely in respiration than the ribs at the left side. There was no bulging of the right intercostal spaces whatever, but on the contrary, the intercostal sulci were deeply marked. Over the whole of the right side of the thorax the vibration of the voice was imperceptible to the hand, whilst over all parts of the left side of the chest it was very strongly marked. Finally, bronchial respiration was very plainly audible over every part of the right side of the chest, but it sounded as though it were distant, and there were no rales whatever accompanying it.

On the most careful examination, it appeared that the left lung was perfectly healthy, and although the heart beat feebly and rapidly, yet there was nothing in its sounds or rhythm indicative of disease.

There was no expectoration whatever, and if the patient's account of herself were to be credited, there had been none all through her illness.

That there was extensive pleural effusion in this case could scarcely admit of a doubt, but the nature of the effusion was by no means so manifest.

The history of the disease, so unlike the usual course of dropsy; the total absence of all the symptoms of those organic diseases which usually produce dropsical effusions in the chest; and the absence of every trace of anasarca; led me to

doubt that the case was one of ordinary hydrothorax. The true nature of the malady never occurred to me, probably because there was no appearance whatever of external cancer, and further, the woman was rather of full habit and well nourished, presenting neither the emaciated appearance nor the cachectic colour of malignant disease. On the entire, I thought it was a case of sub-acute pleuritis ending in effusion.

It was apparent to all, that this woman, unless promptly relieved, had only a few hours to live, and it was equally plain that none of the ordinary remedies afforded a chance of saving her. With Dr. Shannon's concurrence, paracentesis was therefore performed with a very small trocar in the usual situation; three pints, by measure, of perfectly limpid serous fluid, of a slightly olive tint, were slowly abstracted; not a drop of blood was lost, not a flake of lymph escaped, but some air rushed in at intervals through the canula as the fluid was evacuated. Immediately after the operation the most marked relief was experienced; she was able to assume the recumbent position at once, her countenance became tranquil, her pulse fell to 100, she drank wine freely, and expressed herself vastly relieved; for myself, I fully expected still more decided improvement, now that her breathing was so much better; but at my next visit she was dead. For some hours after the operation all had been well; on endeavouring to sit up during the course of the evening, however, she suddenly became faint, and died in the most unexpected manner.

The post mortem examination disclosed the following appearances: the right pleura contained a considerable amount of air, and about a pint of perfectly clear fluid, exactly like the liquid evacuated by the operation. There was no trace whatever of either lymph or blood to be found throughout the pleural cavity. The lung was everywhere free from the slightest adhesion to the parietes, nor were there either upon the lung or upon the costal pleura any traces whatever of old inflammation.

The costal pleura was studded here and there with firm cancerous tubercles, varying from the size of a grain of shot to that of a split pea. To the finger they felt like cartilage. On the diaphragmatic pleura there were five or six similar tubercles, of stony hardness and of snowy whiteness. The lung was itself reduced very much in size, its density was vastly augmented, and so was its weight; in colour it resembled certain varieties of greyish marble, and its surface was roughened by a multitude of white cartilaginous-looking scirrhous tubercles, some of which were sub-pleural, others seemed to grow fairly on the surface of the pleura; all were precisely of the same structure as those above noted on the parietal pleura. In the intervals between these tubercles the pleura appeared surprisingly healthy.

A section of the lung disclosed a tissue of un-

common density, and of nearly stony hardness, intermixed with the blue pulmonary structure. At numerous points of the cut surface the patent orifices of the bronchial tubes were plainly visible.

The left lung presented on its postero-superior surface about eight or ten tubercles the size of peas, sub-pleural, and of precisely the same characters as those on the right pleura; everywhere else it was absolutely healthy.

On the convex surface of the liver, near the falciform ligament, there was a solitary white tuber, with a concave surface, as described by Farre. All the other abdominal viscera were healthy. The uterus was small and quite healthy. The brain presented no appreciable lesion.

My friend Dr. Richardson has kindly examined microscopically some of the morbid deposits. He writes: "The stroma is very dense, and there are cells interspersed through it resembling those seen in malignant structures."

Of the true nature of this case I was certainly not aware when I performed the operation. Had I been so I should probably have declined to interfere, although the result would have been the same under any mode of treatment. Were such another case now to occur, I should be likely, with my former experience, to recognise it, for the absence of all indications of those diseases which usually produce hydrothorax on the one hand, and the absence of the febrile disturbance which usually accompanies pleuritis, together with the woman's age, the long-continued thoracic pains, the depressed intercostal spaces, &c., on the other, might furnish sufficient data for a correct diagnosis.

The two cases taken together afford abundant materials for reflection, and may assist hereafter in diagnosis, should similar groups of symptoms present themselves.

Both were females, one aged 44, the other 58.

In both the right lung was the seat of the disease.

In both it was the true scirrhus or hard cancer.

In both thoracic pains, like stitches, shooting through the right side of the chest, with dyspnoea and dry cough, but without fever, constituted leading symptoms from first to last.

In neither was there any trace of external cancer, or of uterine cancer, to lead to a suspicion as to the true nature of the disease.

In neither had there been any trace of hæmoptysis.

In one the disease produced a *contracted side*, great emaciation, and a miserable death by exhaustion after 15 months of suffering. *In the other* it produced a *dilated side*, a compressed lung, sudden and intense dyspnoea, and death by effusion before there had been sufficient time for emaciation.

In one the cancerous deposit occurred chiefly in the tubercular form; *in the other* in the form of cancerous infiltration.

In one the adhesions prevented the possibility of pleural effusion; and in the other the absence of all adhesion prepared the way for the effusion which so rapidly cut short her career.

ON THE USE OF IODIDE OF IRON.

By JAMES TUCKER, M.D., Sligo.

It is now some time* since I ventured to lay before the profession some brief notes on the efficacy of iodide in iron in certain diseases. I beg leave now to add the following brief remarks, which may further serve to illustrate the great power which this medicinal preparation exerts on several of the depressing ailments which are now so frequently met with.

Several weeks ago a delicate labouring lad, about 16 years of age, poorly fed and badly clothed, was attacked with violent and acute arthritic pains, accompanied with, apparently high febrile excitement, for which the antiphlogistic treatment of calomel and antimomials was prescribed, but without any seeming benefit. The severe pains continued, emaciation progressed, and he was obliged to remain in the recumbent posture until ill-conditioned bed sores made their appearance, and the general debility and emaciation became extreme. Porter, wine, and, animal diet were given, still the sores presented a sloughing and spreading border, and there was an offensive smell from his foul yellow skin. After nine weeks' such treatment he became my patient, when, in addition to the nutritive regimen already prescribed, I gave Blancard's pills and cod liver oil, and had warm stimulating ointment applied to the sores. He very soon began to recruit, the sloughing sores granulated, and their cavities filled up, the fetid smell vanished, and the sickly yellow hue disappeared from his skin. He showed a healthy thriving exterior, but as fast as the extensive sores were healing, and they did so completely, colliquative diarrhoea and pulmonary disease became more developed. I still hoped that he might have sufficient constitution to conquer these symptoms, as he had done the former ones. However, a sudden and unexpected attack of pulmonary hæmorrhage carried him off in three minutes. I was told that the large quantity of blood seemed to suffocate him.

The second case which I will adduce is one of general dropsy, from supposed heart disease, which was treated as such for six weeks with iodides of mercury and potassium, squill, broom decoction, and perpetual blister over the cardiac region. This patient was considered to be almost in a hopeless state, the lower limbs had become cedematous, cold, and benumbed, general anasarca had set in, and progressed despite of all the remedies; the lungs were also greatly congested, there was some

* See DUBLIN HOSPITAL GAZETTE, N.S., vol. ii., p. 263.

delirium, and little or no sleep. Such was the condition of this patient when I commenced to administer the iodide of iron; I did not expect that it would directly remove the dropsical state, but that it might recruit the blood, and elevate the animal temperature, as Dr. Christeson says for it in his *Materia Medica*. It had the happy effect of restoring the animal heat and sensation in the limbs, which had been cold and benumbed, and some vital vigour returned to the entire frame.

I then tried hydragogue cathartics, jalap, elaterium, and croton oil, alternately with the acetate, bitartrate, and nitrate of potash, as diuretics, in infusion of digitalis. I found that by these means I removed to a certain extent the dropsical effects, but not the proximate cause, for as fast as these eliminatives would remove the fluid, the same spanæmic state of blood would regenerate more. I then resolved to stop all medicines, save Blancard's pills, and I ordered garlic juice and Indian meal porridge to be taken, desiring that he should live generously under this stimulant, diuretic and analeptic treatment. Diuresis set in, and in ten days all the dropsical fluid was removed, and there was none regenerated. The vital organs seemed to be all in good working order, and continued so for three months; but as the winter approached a relapse set in. Nearly the same symptoms recurred, but not with the same severity, and they are again yielding to the same treatment.

I have seen chronic sore legs in the lower order of the ill fed labouring classes, and of chlorotic females of sedentary habits, to yield in a remarkable manner to the beneficial influence of iodide of iron. Until the blood of such persons be put into a healthy condition there can be no healthy granulations. A striking and successful case of this kind occurred under my care in the person of a respectable female, of about 25 years, of sedentary habits from needle-work, who suffered for several years from an irritable ulcer of the leg, which had resisted every variety of treatment, but which yielded to the constitutional treatment of Blancard's pills and cod liver oil, with the local application of the unguent of *scrophularia nodosa*.

A very intelligent clergyman, who suffered from purpura simplex, brought on by a laborious mission in the back settlements of the United States, informs me that he has experienced the most rapid relief from the use of iodide of iron syrup. He also mentioned that this medicine is called "*elixir gloriosum*" in America, owing to its remarkable recuperative powers.

I have given it in a few cases of malignant scarlatina, where there was little reaction to throw off the disease, and with the best effects in removing it, and recruiting the constitution. It may appear novel to give this chalybeate in such a febrile disorder, but when we bear in mind that the proximate cause is a pestilential poison in the blood, our object should be to strike rather at the proximate cause than at the effect. Iodide of iron

is the only chalybeate that could be well given in this disease, for the iodine appears to be a good safety valve to carry off the iron in a soluble state through the renal secretion where they are both detected. Any excess of the remedy not required in the blood passes off directly to the kidneys through the short *Hepatico-renal semicirculation*, while the portion essential to enrich the blood takes the entire round of the complete circulation.

As the action of iron on the system is not observed until after it becomes assimilated, the simpler and the more soluble and instable the chemical compound that is administered, the quicker will it be assimilated, and its beneficial influence felt. The binary compound of iodide of iron seems to surpass all other preparations of the metal in the solubility and instability of its nature. In it two elementary substances are chemically combined, which in their isolated states are insoluble in water, but in their compound condition are remarkably soluble, suited for assimilation, and almost essential to each other as remedial agents.

OBSERVATIONS ON THE REMOVAL OF UTERINE POLYPL.

By THOS. L. MONAHAN,

Physician to the Dublin North Union Hospital.

I have no original observations to offer on the causes and symptoms of Uterine Polypi. These points have been amply investigated and accurately described by many. I believe all practitioners are agreed that their extirpation or removal are the only means of effecting a radical cure; and for that purpose have recommended the knife, the scissors, the ligature, or caustic. As bad or troublesome symptoms are not unusual after their application, the following case is not unworthy of perusal, as it clearly demonstrates the advantage the *Ecraseur* affords, not merely in the facility of its application, but also in the complete exemption from troublesome symptoms after its use.

Bridget Marks, æt. 48, was admitted into the Dublin North Union Hospital, 1st December, 1856.

History.—She states that she had six children; last was born about fourteen years ago, and that her health had been very good until the last four years, when she had a severe attack of fever; since that period she has been almost daily subject to menorrhagia, generally profuse, and occasionally large clots came away.

Symptoms on admission.—Great debility, general anæmic appearance, pain in back, and profuse hæmorrhage; the bowels regular; sometimes diarrhoea is complained of. On examination I found a large polypus in the vagina, attached by a pedicle three or four inches long, and two inches in circumference, to the posterior surface of the anterior wall of the cervix uteri, about an inch above the os, which was in a patulous condition.

Dec. 3.—Assisted by Dr. Johns, I applied

the chain of the *Ecraseur* round the pedicle of the polypus, and after some turns of the instrument it was completely detached. Not a drop of blood was lost during or after the operation. The patient being under the influence of chloroform, complained of no pain.

Dec. 11th.—It is now eight days since Marks was operated on; she has been gradually gaining strength; there has been no hæmorrhage, and the pains in the back &c., have almost completely disappeared.

Dec. 12th.—Dr. Johns kindly examined Marks this day, and found the uterine organs, &c., in a normal condition.

The polypus weighed three ounces, was of an oval shape, and of a fibro-cartilaginous substance.

PATHOLOGICAL SOCIETY OF DUBLIN.

A meeting of the Pathological Society was held on Saturday, December 20,

DR. BANKS, V.P., in the Chair.

Tumor of the Nates, Congenital.

Dr. M'CLINTOCK exhibited a female infant which had been born alive at the full period of gestation, having a large tumor attached by a flat pedicle to the nates, transversely across from side to side, and behind the anus. This tumor, which was considerably larger than a goose's egg, was covered with integument, except towards the distal end, where the skin was replaced by thin transparent membrane, in which was an aperture the size of a halfpenny, opening into the interior. Immediately after birth it was observed that blood was flowing pretty freely from the interior of the bag, and through the orifice just described. The effects of hæmorrhage were soon visible in the child's visage, and a ligature was applied round the neck of the growth. However, the child only survived for half an hour. This tumor, or more properly this bag or cyst, was partially occupied by a red, fleshy, soft mass of cerebriform or encephaloid character, highly vascular, and of a very friable, infirm texture, which probably would account for the cause of the hæmorrhage after birth, the compression which this growth had been subjected to *in partu*, having lacerated its structure. This tumor had no connexion whatever with the pelvic viscera, or with the medulla spinalis. In other respects this child was well grown, and presented a healthy structure and normal configuration. Mr. M. H. Collis was good enough to submit a portion of the tumor occupying the interior of this bag to a microscopic examination, and he reports it to be "composed of delicate areolar tissue and small granular cells, in fact, to be a very delicate kind of cellulo-fibrous tumor, full of capillaries, and highly vascular."

Acute Arthritis Genu.

Professor R. W. SMITH exhibited the knee-joint of a patient who had been under Dr. Hutton's care, in the Richmond Hospital, for acute inflammation of the joint. About nine weeks before his admission into hospital he had received a severe injury in his knee, but he continued to use it as well as he could, and as long as he was able. All the usual characteristic signs of arthritis were present on his admission into hospital, and it was manifest that the structures composing the joint were being rapidly disorganized; there were also external abscesses, one in particular of very considerable extent, which passed up from the popliteal space, on the posterior aspect of the femur, totally setting aside all idea of excising the knee-joint. Amputation was performed by Dr. Hutton, in the usual place; and an examination of the interior of the joint exhibited a remarkable example of arthritis of the knee-joint, which had engaged, most extensively, the mucous membrane, cartilaginous and ligamentous structures. The bones were healthy.

Congenital Dislocation of the Knee-joint.

Professor R. W. SMITH exhibited a specimen of congenital dislocation of the knee-joint; the original defects in the articulation consisted in an arrest of development of the outer condyle of the femur; there was no trace of its ever having existed; the patella, which was atrophied to a remarkable extent, was joined by a fibrous tissue to the outer surface of the inner femoral condyle; the bones of the leg were rotated completely outwards, the fibula lying behind the tibia, with which it was ankylosed superiorly. The subject of this malformation was an adult male, who stated that he had never suffered from disease of the joint, nor had it ever sustained any injury. The specimen was a perfect representation of the knee-joint of a man at present under Professor Smith's care, in the Richmond Hospital, who had also congenital luxation of several other articulations. Both these cases will be published in full, in a future number of the GAZETTE.

ASSOCIATION OF THE KING AND QUEEN'S COLLEGE OF PHYSICIANS IN IRELAND.

A meeting of the Association of the College of Physicians was held at the College Hall, on Wednesday evening, January 7th.

Dr. HENRY KENNEDY read a paper on the varieties in appearance of the spots which occur in fevers, especially with regard to diagnosis. He did not seem to consider that there was any such constancy in the different appearances of the eruptions as to warrant our founding any classification of the differences of fever on the characters of the spots. The paper gave rise to considerable discussion among the fellows and licentiates.

Dr. McCLINTOCK, after making some remarks upon the subject of therapeutic diagnosis generally, stated, that having had occasion to administer mercury to many cases of uterine and peritoneal inflammation, during the last two years (all of them connected with pregnancy or the childbed state), he was much struck by the rapidity with which the specific action of this mineral was produced in the system—a few grains of calomel or blue pill being sufficient, in many instances, to cause ptyalism, salivation, and even ulceration of the gums and cheeks. At the same time he had observed that no corresponding benefit resulted from these constitutional effects of the medicine. These facts he explained by the adynamic or ataxic type, which characterized the class of cases that had come under his notice, and which, he believed, formed a predominant feature in most of the acute diseases of the present day. He considered that the readiness with which the system was brought under the influence of mercury showed it to be most unsuitable, on the general principle that a remedy adapted to a disease is borne in larger quantity, and apparently with more impunity, than at other times; the disease appearing to set up in the system an active antagonistic to that of the remedy. In proof of this proposition, he noticed the remarkable tolerance of wine and stimulants in typhus; of opium in perforation of the intestine, and in hæmorrhage, &c.

SURGICAL SOCIETY OF IRELAND.

A meeting of the Surgical Society was held at the College of Surgeons, on Saturday evening, January 10th,

The PRESIDENT in the Chair.

The Secretary read a communication from Dr. COLVAN, of Armagh, in which he stated, that for upwards of twenty years he had been in the habit of curing cancerous diseases by the application of escharotics. He stated that his experience extended over a hundred cases, and that he had never failed in success. The escharotic which he had found most useful and most manageable was, the *potassa fusa cum calce*, which he was in the habit of making into a plaster with crumb of bread and a little mucilage. For some time he had experienced considerable difficulty in limiting the extension of the eschar; but he had succeeded in controlling this by the application of plaster-of-paris all round, and confining the escharotic by a bandage to the diseased part. He was in the habit of leaving the application in contact with the disease for about six hours and upwards, and afterwards applying an opiate cataplasm. The cases invariably got well. He detailed two cases; one of a cancerous wart, which he removed from the forearm in this way, and also exhibited a drawing of a second case, in which he had, by similar means, cured a cancerous ulcer of the leg.

Those statements of Dr. Colvan were confirmed by the written statement of Dr. Robinson, of Armagh, who said he had witnessed many, if not most, of Dr. Colvan's cases.

Dr. HALPIN, of Cavan, sent for exhibition to the Society a cast of the abdomen of a patient in hospital, in the Cavan Union, in which the superficial abdominal veins were greatly enlarged and varicose. In 1852 the patient had had severe dysentery, from which he recovered, and had had afterwards a cutaneous affection of the lower extremities. It was left to the Society to surmise what was the cause of the phlebotic enlargement.

Dr. BELLINGHAM exhibited the heart of a child eight years of age, who had been under his observation for about a year. He had had palpitation, was considerably emaciated, and affected with purpura hæmorrhagica. He died of pulmonary phthisis. The heart was exceedingly small, not larger than that of an infant of three months, but it was perfectly normal in its proportions, and in its valvular apparatus, except that there were two small soft (apparently warty) growths from the mitral valve.

The heart in question weighed 2 ozs.; it measured, from the base of the auricles to the apex of the left ventricle, 2 inches 10 lines; and across the base of the ventricles, $2\frac{1}{2}$ inches. The cavity of the left ventricle, from the edge of the mitral valve to the apex, measured 13 lines; from the edge of the aortic valves to the same point, 1 inch 7 lines; the width at the widest part being 9 lines. The cavity of the right ventricle, from the edge of the pulmonary valves to the apex, measured 1 inch 2 lines; its width, 6 lines.

ABSTRACT OF THE PROCEEDINGS OF THE BELFAST CLINICAL AND PATHOLOGICAL SOCIETY.

December 10th.

The PRESIDENT in the Chair.

Case of Suspected Abdominal Aneurism.

SURGEON HARKIN introduced a patient, R. K., æt. 27 years. The nature of his disease he considered obscure, and he wished to have the opinion of the members as to whether an abdominal aneurism existed or not. Since July 17th he had attended him repeatedly, owing to his being seized with sudden fits of fainting and debility. On examination Mr. Harkin discovered a strongly marked abdominal pulsation, and a loud bruit de soufflet, which was heard most distinctly to the extent of three inches from the umbilicus, in a direction towards the right costal cartilages. Though there were no indications of anæmia, he was decidedly of an hysterical temperament. The opinion of the Society generally was, that no organic disease existed, but that the case was one of a functional derangement, probably depending on gastro-intestinal irritation.

The Secretary presented, from DR. HANNAY, of Lurgan, a series of engravings of pathological specimens in the Military Hospital. The Secretary was directed to convey to Dr. Hannay the thanks of the Society for his contribution to the Museum.

MR. BROWNE exhibited a

Fatty Tumor removed from the region of the Axilla.

It weighed four pounds, and was of four years' growth. He was of opinion that the disease originated in a fatty degeneration of the glandular structure, the outline of a number of these being still distinct in the morbid mass.

DR. SEATON REID exhibited

Diseased Ovaries, Kidneys, and Bladder,

recently removed from a patient who died in the Union Hospital. The patient had been sent in suffering under dysenteric symptoms of eight days' duration, associated with vomiting, and frequent calls to pass urine, with much pain in the region of the bladder. At the first visit the dysuria was looked upon as sympathetic with the irritation in the rectum, but on being much complained of on the next day, it led to a more minute examination of the region of the bladder, where an elastic tumor, evidently containing fluid, and partially moveable, was discovered. As it was possible to be a distended bladder, the catheter was passed, but failed to obtain any urine, and it was then considered to be ovarian. The patient's age was near 40, and she stated that she had been pregnant five or six times, that she had ceased to menstruate at the age of 31, and that for the last year she had suffered much from frequent calls to pass urine, and pain in the hypogastric region. The catheter was passed a second time, but failed to obtain any urine for the purpose of examination. The vomiting continued, the evacuations, which at first were yellow and fluid, became now bloody and rather viscid, and she died at the end of 48 hours more, without convulsion, and remaining sensible till near the close. On *post mortem* examination both ovaries were found diseased, the right was considerably the larger, and on its being laid open, a band with a rugged edge was found encircling the interior, most probably the remains of a cyst that had burst at some former period, and there was also found a small sessile cyst, containing a reddish fluid; the left ovary was changed into one cyst, containing a clear fluid. The uterus had become reduced in size to that of a very small virgin uterus. The bladder was found contracted, greatly thickened, and rough internally, and containing a small quantity of bloody purulent fluid; the ureters were widened and thickened, the pelves of both kidneys enlarged, and containing a fluid similar to that in the bladder, the lining membrane of the right was found granular, and had numerous bloody points on an ash-coloured surface; the membrane of the

other pelvis, although thickened, still remained smooth. Dr. Reid considered that we were justified in supposing that the cessation of the catamenia at the age of 31 was indicative of the commencement of the ovarian disease, as she was then too young to suppose it had ceased in the ordinary course of events. The well known sympathy of the bladder, with an irritated rectum, caused him to overlook at first the serious vesical disease, which had been in existence for the previous year, and the exhaustion and irritation of which were no doubt the cause of her death. He also suggested whether the vomiting and dysenteric symptoms were not indicative of an attempt to establish a vicarious discharge from the stomach and bowels, for the purpose of eliminating the urea, which the diseased state of the kidneys prevented from passing off in the usual way. This view he considered supported by a case recently published by Dr. McDowel, of Dublin, in which urea was detected in the vomited matters; and also by the fact that dysenteric symptoms are not uncommon in the advanced stage of Bright's disease, and that in this patient no ulceration was found on either the small or large intestine, the lining membrane being only intensely engorged, or perhaps inflamed. Dr. Reid also considered some interest was connected with the withering effect the ovarian disease had exercised upon the uterus, reducing it to so small a size, after giving birth to five or six children, and when the female had only reached the age of 40.

DR. T. C. CORRY, presented the

Dismembered Remains of a full-grown Fetus.

The history of the case conveying a sad lesson of obstetric practice in the hands of uneducated midwives. December 10th, he was requested to visit a poor unmarried and unfortunate woman, æt. 35 years, who had been 48 hours in labour. This was her first confinement; and on enquiry, Dr. Corry found that there had been an arm presentation, but the midwife, in her anxiety to effect delivery, had torn it from the body; he subsequently discovered that one of the thighs was fractured, the body having been forcibly brought down, and from the extractive force which had been applied, that the body was now barely attached to the neck by but a slender fold of integument, which giving way, the uterus contracted upon the head and neck. Dr. Corry now obtained the valuable assistance of Dr. Dill, and with difficulty they succeeded in emptying the uterus of its contents. Craniotomy having been first performed, the common blunt hook was found too short to be of any service. Dr. Dill suggested the use of an extractor made for the occasion, resembling somewhat the crochet, only longer. The operation was performed when the patient was under the influence of chloroform. She never rallied, but died from exhaustion in about 48 hours after.

December 20th.

The PRESIDENT in the Chair.

DR. HALLIDAY brought before the Society a young female aged 13 years, having a

Tumor in the Hypogastric Region,

the nature of which was very obscure. Her mother stated that she had observed it for the first time, about two months ago, since which period it had continued to increase, until it had now attained the size of a melon. There were no evidences of puberty, the menses had never appeared, and her health seemed good, urine was passed freely, and the bowels were acting. The tumor, however, was somewhat painful, without any discoloration. The Members were divided in opinion as to whether it might arise from obstructed menses, impacted feces, or be of a malignant nature.

DR. MURNEY exhibited a

Specimen of a Deformed Skeleton,

and gave some account of its peculiarities. About three years ago, the subject of this notice, a man about 40 or 45 years of age, was admitted into the hospital, labouring under bronchitis. From his inability to speak any but the Irish language, his place of birth, precise age, &c., could not be ascertained. After remaining some time in hospital he succumbed to the bronchitis. Among the peculiarities described were the following: About the base of the skull, the different muscular impressions were remarkably prominent; the spine presented the unusual arrangement of a sixth lumbar vertebra, the adjacent dorsal and sacral regions being composed of the usual number of parts. The axis, or second cervical bone, was well shaped in every respect, save that there was no development of the odontoid process. It could not be ascertained if the ligaments which connected the head to the spine presented any peculiarity, as the absence of this process was unknown until the complete maceration of the specimen had been effected. All the bones of the extremities were, as nearly as possible, about half the average length, considerably curved, and presenting the muscular impressions in a most exaggerated form. The head of the femur and humerus were almost completely flattened out, and the trochanters and insertion of the deltoid were enormously developed. Some of the long bones of a tiger were shown, and the many points of resemblance between those and the skeleton were dwelt upon; Dr. Murney remarking, that this but corroborated the frequently repeated observation, that in cases of variation from the normal standard in the human subject, we have the natural condition of some other portion of the animal kingdom assumed; he also directed attention to the remarkably curved condition of the bones in both forearms, more particularly the radii, the appearance naturally suggesting the idea of ostio-malacia, or mollities ossium; this he con-

sidered of some little interest, as all the cases which have been described of that disease have occurred in the female.

The Secretary read a communication from Surgeon M'GOWAN (Tanderagee), detailing the history of a

Case of injury of the Scrotum,

caused by the horn of a cow. The testicle protruded, the tunica vaginalis being quite exposed. Under judicious treatment, the wound healed in a few days, without a bad feature, no symptoms of inflammation of the testicle having been manifested. DR. MURNEY narrated the history of a similar case.

The Secretary read a paper contributed by Dr. H. THOMPSON (Omagh), on a case of

Paracentesis Vesicae.

William Elkin, æt. 80, affected with symptoms of prostatic disease for some years, was seized with complete retention on the 31st January, 1856. I saw him on the 4th of February. Many vain attempts had been made to pass an instrument, and the urethra was riddled with false passages; in order to give these a chance of closing, I deferred any attempt at relieving him until the following day, having prescribed a hot bath and a purgative, which he required. On the 5th I tried to get in an instrument, but could not succeed; so I had no alternative but to tap the bladder, which was accordingly done by means of a long curved trocar and canula, above the pubis. A gallon of high-coloured urine flowed away, with complete relief. I left in the canula for two days, and then replaced it by a gum-elastic catheter, to the free end of which I attached a large-sized Indian rubber ball, fitted with a quill and a peg, by way of a stop-cock, which acted as an artificial bladder, and succeeded perfectly in keeping him dry and comfortable; he went on in this way very well until the 25th February, when I made another attempt to pass a catheter per urethram, and with great difficulty got through No. 6; the prostate was much enlarged laterally, and the passage through it seemed to be very narrow and tortuous. The instrument was left in for a few hours, but finding that he could not bear it, that its presence, whenever attempted, produced a tendency to urinary fever, and considering the extreme difficulty of passing the instrument, and the determination of the old man not to leave his home, which was at too great a distance to admit of his being regularly attended, even supposing the use of the instrument had been unattended by any bad consequences, I had no other course open to me but to leave him as he was. He has been ever since in the state described above, with the catheter constantly in the bladder, through the opening above the pubis, and the ball receiving the urine as it flows away. He suspends it to one of his buttons, and walks about his farm, much more at ease than he had been for some

months before the operation. I certainly never saw, and I do not remember to have read of, a case in which an instrument was retained in the bladder for so long a time. It tends to prove that the bad effects which so frequently follow the continued use of an instrument in these cases depend more upon irritation of the prostate than on the coats of the bladder, and that in cases similar to this, there is a better chance of prolonging life by the proceedings here adopted than by persevering in the use of the catheter in the usual way. The catheters are of course changed as they wear out.

Selections from British & Foreign Journals.

On Syphilisation in Children. By M. BOECK, Prof. of Med. in the University of Christiana.

(*Resumé of a work published by this Author, at Christiana, illustrated with Plates. &c.*—Arch. Générales de Med., Novembre, 1856.)

The author, one of the most persevering and consistent advocates of the doctrine of syphilisation, as well as one of the most unwearied investigators of this subject, has added another memoir to those he has already published on this subject. The results which he has obtained, and which he has made public in his former essays, justifies him, he conceives, in concluding: 1st, that repeated inoculations with the syphilitic virus, for a period sufficiently prolonged, determine an absolute immunity from the disease. 2nd, that all syphilitic symptoms which appear at the commencement of the syphilisation, vanish when the inoculation has continued for a little time. 3rd, the general health is in no way altered by the treatment by syphilisation, on the contrary, the patient feels better after than before the treatment.

These conclusions, laid down since 1854, have served as a starting-point for further observations. Although, as its title indicates, the principal end of this memoir is to treat especially of the syphilisation of infants, yet the author likewise sets forth some observations which he has made during the last two years on adults.

"It is superfluous, I hope," says M. Boeck, "to observe that I only employ syphilisation in the treatment of patients affected with constitutional syphilis, and that I consequently only introduce into the system morbid elements which it already contains. I have always been the declared adversary of prophylactic syphilisation, for it seems to me an absurd idea to pretend to preserve mankind from a malady which every man can avoid if he pleases."

The author has made no change in the mode of syphilisation; he takes the matter of a primitive chancre, and inoculates the patient with it, usually on the arms or thighs; he makes three inocula-

tions on each thigh and on each arm; in some cases he inoculates on the sides of the chest, the place of inoculation adopted by Sperino, because here the cicatrices are less obvious. He generally makes use of the pus obtained from the previous inoculations, but he tells us, that out of a hundred chancres thus produced, one rarely finds more than twenty or thirty that arrive at any considerable size, or leave any evident cicatrices.

Two or three months are in general necessary, in order that the inoculations may become negative; then the immunity is complete, the effect will be just the same whether we inoculate with distilled water or syphilitic virus, absolutely no result. This law knows no exception.

M. Boeck enters at some length into the question of whether the syphilitic virus is invariably of the same degree of activity; in this respect he finds that individual peculiarity makes much difference, as may be observed by inoculating several different persons with the same poison. When a series of successive generations of chancres has been produced by inoculation, he observes, the early generations yield a pus sensibly more active than the later crops.

Individuals who have been mercurialised are less amenable to the treatment by syphilisation than those who have not; as a general rule, they require a longer time than others, from four months to a year, and even then all fear of relapse is not removed. Out of thirty-seven patients syphilised, who had been first treated by mercury, seven had slight re-appearance of the disease.

When the usual symptoms of constitutional syphilis exist, as insomnia, fatigue, rheumatic pains, &c., they disappear on syphilisation, and the patient often gains a certain amount of *embonpoint*. Probably, continues M. Boeck, medical men who have never either practised or witnessed the syphilisation of a patient, will receive this assertion with doubt, but experience has proved it. At the end of three or four weeks of treatment syphilised patients affirm that they feel better; at the end of the syphilisation they can resume the most laborious employment. One might think very reasonably that if a single chancre produces so much general disorder, some hundreds of inoculations would only multiply the peril, but it is not so.

M. Boeck commenced his series of experiments on children with much timidity; the event, however, fully reassured him; his fears he found had been vain, the artificial chancres were so small that they hardly yielded matter enough for the successive inoculations; in one case fifty inoculations were made, of which only twenty-four succeeded in producing chancres; all the ulcerations were very small; at the end of four months immunity was complete, the same period which is necessary to establish immunity in adults. In a second case of syphilis, in a child six months old, thirty-eight inoculations were made, of which only

twenty-three produced artificial chancres; immunity was complete four months and a half after the commencement of the syphilisation, all the symptoms having then disappeared. In a third case, which M. Boeck briefly relates, 135 inoculations were practised, of which 104 produced chancres; in this case, although the symptoms began to amend from the fourteenth day, yet immunity was not attained sooner than in the other cases, in four months. In no case treated by M. Boeck in this way, has the general health of the child suffered; they continue to fatten and thrive well.

M. Boeck concludes by observing, that all the world knows how badly children bear mercurialisation, which exercises so baneful an influence on their system, when it does not altogether destroy them; the length of duration of the treatment is no objection at this age, and on these grounds he advocates this mode of cure.

Memoir on Cysts in the Popliteal region. By Dr. E. FOUCHER, Prosecteur de la Faculté de Médecine, a Paris. Archives Générales de Med., Octobre, 1856.

Dr. Foucher in this paper gives, at considerable length, an account of the various cysts which are met with in the Popliteal region. These cysts are commonly formed, he tells us, by a dropsy of one of the synovial sheaths of some of the tendons in this region, especially those on the inner side of the ham. Cysts formed in this manner occupy either the inside or outside of the space; those which lie in the middle being generally due to an unusual development of one of the synovial follicles, or a hernia of the synovial membrane of the knee, but of the two varieties the latter is by much the rarer. Serous, hydatid, and even blood cysts, are occasionally met with in this region.

The synovial cysts are either reducible or irreducible. The reducibility which is readily effected on flexing the knee implies that the cyst communicates with the joint. The most frequent complication is hydrarthrosis, which is either primitive or consecutive; it may accompany any variety of cyst, but principally those met with in the middle of the ham. The diagnosis of these cysts is, generally speaking, easy, and the best treatment lies in repeated blistering and iodine injections.

Of Bleeding from the Ear in consequence of blows on the Chin. By A. MORVAN, Ex-Chirurgien de la Marine, &c. Archives Générales de Med., Octobre, 1856.

The observations of M. Morvan tend to prove that severe falls and injuries on the chin are more likely to be attended by fracture, traversing the petrous portion of the temporal, than by fracture of the glenoid cavity, and this remarkable fact he supports, not only by cases, but by the result of direct experiment on the dead-subject. A block of wood having been placed under the chin of a

subject about 40 years of age, several smart blows of a mallet were applied in the direction of the axis of the bone; subsequent examination showed that the glenoid cavity of the temporal bone was uninjured, but considerable fissures were found traversing the base of the cranium, and extending across the petrous portion of each temporal bone.

In another experiment on a subject 30 years of age, the same block of wood was applied beneath the angle of the jaws, and the blows of the mallet made upwards, and in a somewhat oblique direction; the result was, on the left side, a fracture of the ramus of the jaw in its lower third; on the other side, fracture of the petrous portion of the temporal, as in the former experiment.

Up to the present time we have only recognised fractures of the base of the cranium by *contrecoup*, as the result of injuries acting from above downwards (as falls, blows, &c., on the top of the head), and injuries acting from below upwards (as falls on the feet, knees, tuberosities of the ischium); henceforth it will be necessary to add to these, violence applied from before backwards, as in falls, blows, &c., on the chin.

M. Morvan concludes that blows on the chin may cause hæmorrhage from the ear, without any laceration of the membrane of the tympanum; but when this accident does occur, we may expect to find a fracture either of the glenoid cavity, or of the petrous portion of the temporal bone, or of both. When bleeding from the ear occurs without rupture of the membrane of the drum, the idea of fracture of the petrous portion may be set aside; it is fair to presume that there is only a fracture of the glenoid cavity. Besides an abundant bleeding from the ear, with perfect integrity of the membrane of the drum, fracture of the glenoid cavity is evidenced by such sensibility in the temporo-maxillary articulation, that mastication and deglutition become excessively painful if not impossible.

In fractures of the petrous portion of the temporal bone, bleeding from the ear, and rupture of the membrane of the drum, are the most important symptoms.

If there be at the same time fracture of the glenoid cavity and of the petrous portion, there will not only be hæmorrhage from the ear, rupture of the membrane of the drum, but also pain and difficulty in mastication and swallowing.

Phlebitis in consequence of forcible extension of Ankylosis of the Knee Joint. By Dr. H. FRIEDBERG: Prag., Vjhrschr, xiii.—2.—1856.

Although the author of this memoir assures us that he has met with the most gratifying results from forcible extension of the knee joint, in some cases of old ankylosis, performing this painful operation under the influence of chloroform, and without having recourse either to tenotomy or instruments for the purpose of extension, yet he

admits that as a consequence of this *brisement forcé* he has more than once known fatal phlebitis to supervene.

Bonnet, in his memoir on the rupture of Anchylosis (Gaz. Med. de Paris, 1850), Langenbeck, in his essay on the same subject, and Schuh (Wien. Med. Wochensh.: 1853) have not mentioned phlebitis as one of the consequences of forcible extension of ankylosed joints; and it would seem that these surgeons have been so fortunate as not to have met with this accident in their practice. The author from his experience is led to conclude that forced extension of the knee joint, in cases of ankylosis, becomes likely to be followed by phlebitis, from the following circumstances:—1st, when excessive contraction has flexed the knee to a very acute angle; 2nd, when the soft parts around the joint are much matted together and brawny; 3rd, when there is evidence of caries existing in the joint; 4th, when there is any prevailing edidemic of phlebitis or pyæmia.

In the two first, when the knee is much bent, or the surrounding parts are very unyielding, there is a risk that the popliteal vein may be injured, or even lacerated; to avoid which it is advisable to straighten the limb by several successive efforts at extension. When caries is supposed to exist within the joint, the procedure by *brisement forcé* is contraindicated; slow and gradual extension being much safer and more applicable to such cases.

Correspondence.

To the Editor of the Dublin Hospital Gazette.

Dublin, 3rd January, 1857.

SIR,—I have just perused Dr. T. O'Brien's communication on operations for elephantiasis of the scrotum, performed by him in Calcutta, and I am much surprised at the large proportion of fatal cases reported by him, viz., 3 out of 22. If I mistake not, the hospital Dr. O'Brien alludes to was established some few years ago by the Indian Government as a mesmeric hospital, and placed under the sole charge and control of Dr. Esdaile, whose success in operations on tumors was unparalleled in surgery. Now it would be very interesting and satisfactory to have before us a comparative statement from the records of the hospital, of the number and results of mesmeric operations by Dr. Esdaile, and of those under chloroform by his successors, including Dr. O'Brien; and perhaps that gentleman would be kind enough to furnish you with such a statement. My impression is, that the deaths under Dr. Esdaile's mesmeric treatment never exceeded three per cent.; and if I am correct, why has mesmerism been banished from the hospital in question? Pray excuse my troubling you on this matter, though it appears to me to be one worthy of some notice and consideration.—I am, Sir, yours &c., A. R.

Reply to "SUBSCRIBER," on Issue-making.

During the discussion on Dr. Colvan's paper, at the Surgical Society, on last Saturday evening, Dr. Geoghegan said that he had been long in the habit of inserting issues, by first applying a blister of the required size, and when the cuticle was removed, touching the cutis lightly with *potassa fusa*. Several members present confirmed the value of this mode of inserting issues.

COMMUNICATIONS received from A. R.; Dr. M'Clintock; Dr. Tucker (Sligo); Mr. Fowler; &c.

NOTICE

TO SUBSCRIBERS AND CORRESPONDENTS.

The management of the Commercial Department of the DUBLIN HOSPITAL GAZETTE has been handed over to Messrs. BROWNE & NOLAN, 21, Nassau-street, Dublin, who will henceforth print and publish it; to whom all subscriptions are in future to be paid, and all communications for the Editor addressed.

CHANGES IN THE MEDICAL DEPARTMENT OF THE INDIAN ARMY.—The *Athenæum*, an Indian paper, says:—That our medical readers may learn the changes which rumour alleges are to be made in their department, we may mention that our present information is to the effect that Dr. McLennan, who lately retired from the Bombay Presidency after having attained the rank of Physician-General there, is to return in the capacity of Director-General of the Medical Department for all India. Subordinate to him, in each presidency, there is to be one civil and one military Inspector-General; according to the *Delhi Gazette*, the class of superintending surgeons is to stand, but, as we suppose, subject to the operation of the staff rules, so as to insure their displacement at the end of five years, and allow a constant succession of younger men to fill their important offices. The cry for promotion is urgent, and the quinquennial removal of the superintending surgeons will give it, while their immediate condition as to pay will not be worse than that of the major-generals who are removed on promotion. Our own information coincides with that of the *Delhi Gazette*, as to the formation of a class of staff-surgeons; but the exact position they will occupy, whether they will replace the present garrison surgeons or be aides to the superintending surgeons, we have not learned. There are rumours, also, that the existing orders regarding rank and position, which should never have been issued, are to be abrogated; and that assistant-surgeons in charge of corps, who now draw only 165 rupees a month, are, after eight years service, to draw 300 rupees, as surgeons at present do. The medical staff appointments, in all cases, are to be made by selections; and this duty is to be left to the Director-General to perform.

MILITIA SURGEONS.—The *Dublin Evening Mail* states that it is intended shortly to employ surgeons of the militia in recruiting for the line regiments, and other duties connected with the service, so as to relieve, to a certain extent, the regimental surgeons, thereby enabling these latter to pay greater attention to the sick of their respective corps, and also to attend more closely to the hospital department with which they are connected.

Obituary.

DR. URE.—Dr. Andrew Ure was born in Glasgow, in the year 1778, and graduated in the University of that city in 1801, becoming a Member of the Faculty of Physicians and Surgeons in 1803. He held for some time the post of Professor of Chemistry in the Andersonian University, where for many years he also delivered a systematic course of lectures on materia medica. In 1818 he published an interesting memoir, entitled "New Experimental Researches on some of the leading doctrines of Caloric, particularly on the relation between the elasticity, temperature, and latent heat of different Vapours, and on Thermometric Admeasurement and Capacity." In the same year he also published the details of some experiments on nitric acid, on a new explosive endiometer, and on the relation between muriatic acid and chlorine. In 1819 he published an account of some galvanic experiments made on the body of a recently-executed criminal; and another memoir on the constitution of muriatic acid of different gravities. In 1821 appeared the first edition of his well-known "Dictionary of Chemistry," which has gone through several editions, and is still a standard work upon that science. In 1822 he published a paper "On the Ultimate Analysis of Vegetable Substances," which was one of the earliest contributions to the now extensive department of organic chemistry. In 1824 he published a translation of Berthollet's work on Dyeing and Bleaching. In the year 1829 appeared his "System of Geology." In May, 1830, he came to London, and was employed by the Lords of the Committee of Privy Council to institute a series of experiments on sugar refining; and he subsequently, in the same year, became chemist to the Board of Customs. In 1835 he published his "Philosophy of Manufactures," and in the following year his work on the "Cotton Manufactures of Great Britain." His large and laborious work entitled the "Dictionary of Arts, Manufactures, and Mines," appeared in 1837, and the last edition appeared in 1852. He was elected a F.R.S. in 1822, was a Fellow of the Geological Society from its foundation, and was a Fellow of the Astronomical Society for many years.

A few years ago Dr. Ure experienced an attack of apoplexy, followed by paralysis, from which he

in a great measure recovered; but for some time past it has been evident to his friends and relatives that his powers of body were gradually decaying under the influence of advancing years, although he was not seriously indisposed until within a short period of his decease, which occurred somewhat unexpectedly on the morning of the 2nd instant.

Dr. Ure was one of the best chemists of the present day. He had watched the dawn of chemical science at the conclusion of the last century, and contributed materially to its advancement by his lectures, researches, experiments and published works. He was an able and fluent lecturer, a clear and concise writer, and a careful analyst. He cannot properly be classed with those philosophers whose original genius has placed them in advance of their age, or whose discoveries have startled the world by their importance to mankind; but Dr. Ure must always be remembered with respect as one of the most zealous cultivators of natural science in a century distinguished by the labours of such men as Davy, Faraday, Wollaston, Henry, Turner, whose labours have not been confined to the library or the laboratory, but who have connected the mysteries of science with the progress of the arts, and have introduced the symbolic expressions of chemistry and natural philosophy into the language of common life.

January 9, at Oxmantown-place, Parsonstown, JOHN WATERS, Esq., M.D., L.R.C.S.I. The disease which caused his death was acute inflammation of the lungs, which rapidly set in, resisted all the remedies used, and proved fatal in a few days. His loss will be largely felt, and his place, either privately or professionally, hard to fill.

On the 12th instant, at his country residence, near Bray, RICHARD MORRISON, Esq., M.D., L.R.C.S.I., of Leeson-street, aged 59 years.

ADVERTISEMENTS will be received for the DUBLIN HOSPITAL GAZETTE by BROWNE & NOLAN, to the 12th and 28th of each month. The following is the

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CLINICAL REPORTS OF MEDICAL CASES.

By J. T. BANKS, M.D.,
King's Professor of Physic.

Perforation of the Aortic Valves—Loud Musical Murmur.

A woman, aged 34, was admitted into the Whitworth Hospital on the 25th of last November. Her health had been good up to three years since, when she had cough, and occasional attacks of hæmoptysis; but after some time she regained her health, at least to a considerable extent. She never had acute rheumatism. About four months before she came into hospital, she, for the first time, felt there was something wrong about her heart; she "felt an extraordinary fluttering;" and from this time she had palpitations, which were augmented by any exertion, and her breathing became short. Two months after, she experienced symptoms calling her attention to her heart; she heard a noise as she lay in bed, it was like the cooing of a pigeon. She could not conceive where this sound existed; she searched her room, and even ripped open the mattress upon which she lay, to try and find out if there was any living thing in it which could make the noise. At length, finding that she heard it as she walked about, and as she lay in bed, and equally loud under all circumstances, she was forced to the conclusion that the sound emanated from her own body. She was now constantly sleepless at night, kept awake by the noise; she spat blood in small quantity, at times, and she lost flesh; but she worked on for two months, and continued, as she had been in the habit of doing, to carry heavy loads up stairs; but the uneasiness about the heart increasing, and her breathing daily becoming more embarrassed, she was compelled to seek admission into the hospital.

When received into hospital, she stated that her general health was wonderfully good, considering she never slept; but on close inquiry, it was found she meant to convey, by saying she "never slept," that she was perpetually starting from her sleep.

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frightened by the noise, and that it was only short snatches of rest she could get, always feeling unrefreshed, and as if she had not had any. She would "give the world" for one good sound sleep, but that she said she did not expect, unless the noise, which never ceased, could be removed.

Before proceeding to a minute examination, it was evident that this woman laboured under patency of the aortic valves; there was marked throbbing at the top of the sternum, the carotids also throbbed so violently as to cause the whole neck to appear in motion; every artery on the surface beat visibly. The physical signs were those of inadequacy of the aortic valves; the area of the heart's dulness was increased; the signs of hypertrophy of the left ventricle existed; the radial pulse was the jerking or collapsing pulse of aortic patency; but in addition to the ordinary signs, there was audible at the base of the heart, a sound totally different in character from that of the usual murmur to which patency gives rise. It was a distinct musical note, and so loud that it could be heard at some distance from the chest; this sound was audible in the course of the aorta, and was propagated into the carotids, and even into the arteries of the arm. It was a single regurgitant sound, and pervaded the whole chest, so much so as to obscure every other. In vain we endeavoured to hear respiration, for at the parts most remote from the cardiac region, there also was the musical murmur, rendering the breath sounds perfectly inaudible. Percussion could alone be resorted to with a view of ascertaining the state of the lungs; auscultation was valueless under existing circumstances, and percussion did not reveal any abnormal state of these organs. The heart's action was regular, but extremely rapid, and it was usually a matter of extreme difficulty for the ear to separate the two sounds, the loud musical note seeming to be the only sound which existed.

The woman complained of uneasiness in the region of the heart, and breathlessness, but her constant and never-ceasing cry was, for relief from the noise which deprived her of sleep and

rest. She appeared as if she rarely lost consciousness of the presence of this sound. She went on without any notable change occurring for some weeks, except that she gradually declined in strength, the want of sleep more than anything else being the apparent cause. In the morning she always looked worn and haggard.

On the evening of the 21st of December she was as usual, and the nurse reports that she had been speaking to her, and left the ward for a very few minutes; on her return she found that a sudden change had taken place in her; she supposed she had fainted. The nurse summoned the clinical clerk, who found her dead.

The examination of the body was made 20 hours after death. The heart was found to weigh 14 oz. Hypertrophy of the left ventricle, to a considerable extent, existed. The heart was generally enlarged. The aortic valves were cribriform, presenting numerous well-defined openings; the edge of one valve was thickened. Beneath the orifice of the aorta, in the ventricle, and about a quarter of an inch distant, were three little rudimentary valves, at least so they may be termed, from their close resemblance to the semilunar valves. The mitral and tricuspid did not present any lesion. The aorta, in its ascending portion, was the seat of atheromatous deposition. The apex of the left lung presented the cicatrix of what had been a tubercular cavity, proving that a curative process had taken place at this part of the lung.

The case detailed was one which, during life, excited a good deal of interest, from the unusual nature of the sound, which being most intensely loud at the base of the heart, was not, however, confined to the cardiac region, or even the arterial tree, but was heard (to the extinction of the respiratory murmur) over the whole extent of the chest, and even in the arteries of the arm. In speaking of the character of the sound, I have termed it "unusual," and this attribute is, in my mind, not misapplied, at least my own experience in cardiac disease enables me to state, that in the numerous cases of lesions of the heart which come under the notice of the physician every day, this modification of the "*bruit de souffle*" is most uncommon. Lænnec does not refer to it, and when we look for reported cases in which mention is made of a pure musical note being audible at the heart, we cannot but come to the conclusion that the phenomenon is no ordinary one, and that Hope was not justified in stating that the "musical murmur is a common occurrence." Dr. Elliotson, who first called attention to this phenomenon, says, "I have heard it exactly resemble the cooing of a dove, and so loud, that I heard it when standing nearly a foot from the patient." In the 6th vol. of the *London Pathological Reports*, there is a case of cardiac disease given, in which a musical sound is described as resembling that of the common cuckoo-clock, just before it strikes the hour. The musical murmur

which is audible at the base of the heart, and transmitted along the arteries, is not always an evidence of a diseased condition of the aortic valves. Skoda has noticed it in some rare instances, in old persons, whose arteries were converted into nearly solid canals by chalky concretions. The sounds of the heart, especially the systolic, occasionally attains an extraordinary loudness, a ringing and metallic character, which is propagated to the arteries, but we have never known it to be so intense as to be heard at any considerable distance from the patient. Wunderlich, however, says it is sometimes audible even in an adjoining chamber. "*Das klingen ist zuweilen so stark, das es in ziemlich weiter Entfernung, ja selbst in benachbarten Zimmern gehört wird.*"*

In the greater number of cases of cardiac disease which have been noticed as presenting a murmur of a musical character, the lesion which existed admitted of regurgitation, and as far as I can make out, the aortic orifice has been the most frequent seat of the disease. Dr. Stokes, in his work on Diseases of the Heart and Aorta, reports a very remarkable case of cardiac disease with musical murmur. The subject of it remarked to Dr. Stokes that "his entire body was one humming-top." In this case, as in the one I have now reported, the chief suffering arose from the patient being painfully conscious of the noise within his body. I have said the musical murmur is generally found to co-exist with aortic disease, but there are exceptions. In all the examples which have been under my own observation, such was the case; but Dr. Peacock of London, Dr. Bellingham, and others, have mentioned examples of cardiac disease in which the left auriculo-ventricular valve was the seat of the lesion, and in these cases a musical sound was heard. In Dr. Bellingham's case there was a cribriform condition of the curtain of the mitral valve. The most remarkable instance of musical murmur, audible at the base of the heart, and transmitted along the arteries, which I have observed, was communicated by me to the Pathological Society some time since, a report of which is to be found in their proceedings. It was a specimen of inadequacy of the aortic valves. The cause of the musical sound in this case was, evidently, an atheromatous prolongation, more than an inch in length, which stretching up into the aorta, must have vibrated like the tongue of a Jew's harp. In the case under consideration, the sound was so like to that which I had heard in the former, that during the life of the woman, I ventured the opinion that the probable cause of the musical note was a vibrating tongue from one of the valves, or, that like the interesting case reported by Dr. Stokes, irregular ossified deposition existed at the mouth of the aorta. The result of the necropsy proved that neither condition was present, but that the musical sound was caused by a cribriform state of

* Handbuch der Pathologie & Therapie. Von Dr. C. A. Wunderlich.—B. iii. s. 557.

the aortic valves. This case, and many others which might be adduced, prove the difficulty of determining, in numerous instances, the exact nature of the cardiac lesion. The presence of patency of the aortic valves was beyond all question, but the cause of the musical character of the murmur was the point which we were unable accurately to determine; forcibly illustrating the truth of an observation of Dr. Stokes, in his recently published work on the Diseases of the Heart, viz., that "the complications of heart disease are so numerous and varied, that it becomes impossible to determine the exact nature of every case that may come before us."

Empyema.—Thoracentesis.

A man, aged 28, was admitted into the Whitworth Hospital, on the 24th of November, 1866. He was a labourer, and had been in very indigent circumstances. He was frequently exposed to cold and wet, and he had been subject to "coughs." On the 29th of May last, after being much heated, he was exposed to the influence of cold, and on the night following he was seized with rigors and acute pain in his left side, aggravated by an attempt to make a deep inspiration; his breathing was also much oppressed. The day after his illness commenced he was received into the hospital of the neighbouring workhouse. After three weeks' residence in the hospital, he left it much relieved, but in a weak state; he returned, nevertheless, to his ordinary arduous occupation; his breathing, however, continued short, and he suffered from cough, which came on in paroxysms. He continued to support himself by labour until a week before the 24th November, the date of his reception into the Whitworth Hospital; he then, finding himself unable any longer to work, came to Dublin, with a view of gaining admission into an hospital. His state on coming into hospital was as follows:—The countenance was expressive of suffering, and was of a dusky hue, becoming deeper when fits of coughing came on, which were very frequent. The respiration was 30 in a minute, and a deep inspiration caused pain in the left side. Decubitus was on the left side; an attempt to lie on the right, or even on the back, produced dyspnoea. The pulse was 96.

On inspection, the left side appeared considerably larger than the right, and it was motionless. The intercostal spaces were obliterated, the whole surface being quite smooth. The impulse of the heart was visible at the xiphoid cartilage.

On measurement, the left side was found to exceed the right by an inch and half. The sound, on percussion was dull over the entire extent of the left side, except at the apex. Alteration of position had the effect of altering the site of the dullness; the respiratory murmur was inaudible; bronchial breathing, however, could be heard at the root of the lung. The sound on percussion

over the right lung was rather clearer than usual; bronchitic rales were everywhere audible, and the expiratory murmur was very loud and much prolonged. The cardiac sounds were normal, and were most loud and distinct at the median line, at a point corresponding to the xiphoid cartilage, where the impulse could also be felt.

From the day he came into hospital to the 4th of December there was no remarkable change in his state; but from that day his respiration became more hurried, his face more livid, and his condition altogether more unsatisfactory. Respiration, 34 in a minute; pulse 112. It appeared as if it were impossible he could live 24 hours; but the liberal and steady administration of diffusible stimulants had the effect of producing a rally. On the 9th of December the operation of thoracentesis was determined on, and 104 ozs. of sero-purulent fluid were drawn off.

On the evening of the operation the man expressed himself much relieved; his respiration was easier; and on the following day the left side was found to measure only three-quarters of an inch more than the right. He had more quiet sleep, and fewer fits of coughing and fewer paroxysms of dyspnoea than before the operation.

The second day after the drawing off of the fluid, the left side measured exactly the same as the right, and respiration was audible over rather a greater extent than previously. No signs of the presence of air in the pleura, no succussion sound could be heard, nor was there tympanitic resonance.

On the 14th of December the left side was a quarter of an inch less than the right.

On the 18th the improvement continued.—Respiration, 22; pulse, 104. The bronchitic signs at right side not so intense.

On the 20th of December there was a return of dyspnoea, febrile symptoms manifested themselves, respiration became again rapid, the pulse rose to 120, and signs of re-accumulation of fluid were present, paroxysms of cough frequently recurring, during which the face became of a deeply livid hue. Signs of intense bronchitis of the right lung were again discoverable.

From the 20th to the 28th the condition of the patient was hourly becoming more unfavourable. Inspection, percussion, and auscultation proved that the effusion was rapidly taking place, which was, moreover, evident from the increased dimension of the side. The operation of paracentesis thoracis was again resorted to, with the effect of temporary relief from a state in which suffocation seemed imminent: 46 ozs. of purulent fluid were drawn off. The amelioration of the symptoms was, however, very transitory, for on the 30th of December the patient succumbed to the disease.

On examination of the body, the left pleural cavity was found to contain a considerable quantity of purulent fluid, and the lung was solid and carnified, and occupied but a very small space. The right lung was emphysematous, and the brou-

chial mucous membrane exhibited the usual appearances observed in bronchitis. No tubercular deposit existed in either lung. The heart was free from disease, but it occupied a position far to the right of its normal situation, which, it may be observed, it had retained under all circumstances during life.

From the history given by this man of his illness, it is probable, that nearly four months before he came under observation he had been the subject of acute pleuritis, for which he was treated in the workhouse hospital; that the disease subsequently passed into the chronic form, and he was then enabled to return to his ordinary avocations. Bronchitis of the lung, at the opposite side supervening, may have been the cause of the aggravation of his symptoms, and the great difficulty of breathing under which he laboured when received into the hospital. A state of things can scarcely be imagined more eminently calculated to produce extreme dyspnoea than was here found to co-exist.—Pleural effusion at one side, rendering the corresponding lung, so far as respiration was concerned, for the time, valueless, and the opposite lung the seat of disease of a character greatly to interfere with the respiratory process. A more unpromising case could scarcely be conceived. In consultation with my colleague, Dr. McDowell, the operation of thoracentesis was, nevertheless, determined upon; and I conceive that, under the circumstances, it was perfectly justifiable. We knew that unless the patient was relieved, death must occur very shortly, and that by the operation we were, in any case, likely to prolong life, and perchance, even to place him in a position from which we might contemplate the possibility of recovery. The result of the operation confirmed our opinion as to the prolongation of life, and so striking was the improvement in the patient, as at first to lead to a hope of permanent benefit; a hope, however, which proved delusive. It is not my intention to discuss the general subject of the propriety of the operation of thoracentesis in pleural effusions, a matter which has of late received so much attention, at home and abroad; I shall confine myself to the case under consideration. Whatever difference of opinion may exist as to the operation being called for under ordinary states of pleural effusion, there cannot be a question as to the propriety of it when dyspnoea is so urgent as to threaten life. There are cases when a few days of life are of incalculable importance; and even independent of this circumstance, if we can render the few remaining days of life comparatively comfortable, and free from suffering, and that this great benefit can be gained by a trivial and painless operation, surely we ought not to hesitate. Those who closely watched the progress of the case I have narrated, and witnessed the relief obtained by the operation, would not, I apprehend, in like cases, abstain from adopting the course which we did, even with the certainty that the effect of the operation could only

be palliative. The duration of the disease in this instance, and the likelihood of the lung being compressed so long as to have utterly lost its power of re-expansion, should not deter us from the performance of the operation, viewing it as a palliative remedy. The existence of bronchitis and emphysema of the opposite lung, more than the duration of the compressing influence of the effusion upon the left lung, rendered this case a desperate one. The performance of thoracentesis, as a palliative proceeding, has found favour with many physicians, and the results of the recorded experience on the subject warrants us in the expectation that in many cases, when ultimate recovery is not likely, we may at least still hold out the prospect of lengthened days. Legroux (Union Med.) performed in one case 24 successive operations. Wunderlich operated three times in the course of half-a-year, (and each time before the operation death appeared at hand,) with the result of prolonging the patient's life a year, in comparative exemption from distress, the patient finally dying of Bright's disease. In this case, in which our interference had obviously the effect of prolonging life, recovery might have been expected if the operation had been resorted to earlier. I am persuaded that the advice given by Dr. Hughes, of Guy's Hospital, with regard to the operation, is consonant with the experience of all practical physicians:—"My own experience and consideration induce me to believe that it is preferable to tap the chest as soon as all hope of the future beneficial operation of remedies has disappeared; and if possible, before the effusion has been converted from serum into pus." In performing thoracentesis in this case, I employed an extremely small trocar, which I found to answer well, and which I consider is much preferable to the larger-sized instruments generally used for the purpose. The wound inflicted by this capillary trocar was so insignificant as to be with difficulty discernable on the second day after the operation. With regard to the manner of performing the operation, I followed the rule laid down by M. Trousseau.

CASES OF COMPOUND DEPRESSED FRACTURE OF THE SKULL, WITH OBSERVATIONS.

By HENLEY THORP, M.D., F.R.C.S.L,
Medical Officer of Letterkenny Hospital and Dispensary.

Case 1.—Compound Depressed Fracture, without symptoms of Cerebral Compression.—Application of Trephine, and elevation of Depressed Fragment.—Epileptiform Convulsions.—Extraction of a sharp fragment of the inner Table.—Recovery.

On the evening of the 20th September, 1853, Patrick Madden, a servant, æt. 14, was admitted into the Letterkenny Hospital. Half an hour pre-

viously he received a fall from a horse, and before he could recover himself the animal had struck him on the head with the cock of one of the hind shoes.

On admission, the left side of the head, in front of and below the parietal protuberance, presented a lacerated wound nearly two inches in length, through which a depressed fracture of an angular form could be felt with the finger. The apex of the fragment yielded easily to pressure, and was sunken about half an inch below its proper level. The patient manifested no symptoms whatever of either compression or concussion of the brain; there was neither paralysis nor loss of sensation of any part or organ; he walked about, and described accurately the manner in which the accident happened. He appeared to have lost much blood. Pulse 78, compressible. No sickness of stomach. As the patient seemed unwilling to let the wound be properly examined, and was inclined to become unmanageable and violent, I brought him fully under the influence of chloroform. As it soon became evident, by examination with a probe, that the inner table was extensively fractured, and detached from the outer, more particularly in the neighbourhood of the angle where the bone was most depressed, I determined to elevate the triangular fragment. A short incision, at right angles with the wound, enabled me to raise a flap, so as to expose a sufficient surface of the skull. Beyond the point of the fracture, and where the cranium maintained its proper level, I first applied the trephine: a circle of bone, *one-third of which only included both tables*, was easily removed; but as this was insufficient to permit the employment of the elevator, I sawed out another circular portion, *composed also, for the most part, of the outer table*, and divided the narrow neck of bone between the two openings with one of Hey's saws. This enabled me readily to insert the elevator under the depressed angle, and to lever the whole of the V-shaped fragment into its proper position. When this was effected, the greater part of the area of the trephine holes was closed by the inner table. Two small fragments, which adhered but loosely to the dura mater were next extracted, and the flap being replaced, the edges of the wound were gently approximated, and retained in situ with adhesive plaster.

September 21st.—Patient slept well during the night; has no headache; tongue moist; skin natural; pulse 85, rather firm; *mitatur sanguis ad uncias octo*. As his bowels were not moved since the accident, he was directed a bolus, with three grains of calomel, and a wineglassfull of black draught after two hours.

September 22nd.—Bowels well opened; tongue whitish; no headache. To have a grain of calomel and two of James's powder every fourth hour.

September 23rd.—Dressings removed; edges of wound puffy and swollen, with some redness of the neighbouring scalp; water dressing.

September 25th.—Wound presents a much healthier appearance; its edges, however, are greatly separated. This is produced by the retraction of the flap. The skull and a small portion of the dura mater are visible; the former presents a pinkish-white appearance; the pulsations of the brain are perceptible through the latter.

September 27th.—Mercurial futor; gums and cheeks swollen; discontinue the calomel and James's powder. The exposed skull and dura mater are of a bright red colour; wound suppurating freely. With the view of bringing the edges of the latter into a more favourable position, straps of adhesive plaster were again had recourse to, in place of the water dressing.

September 29th.—Mercurial action too severe; considerable swelling of the submaxillary and parotid regions; superficial sloughs on tongue and inside of cheeks; pulse 90; chloride of lime gargle.

October 1st.—Mouth improved; wound doing well; dura mater concealed by granulations, which also appear in isolated clusters on the surface of the skull.

October 3rd.—Entire wound granulating; pulsations of brain still perceptible where dura mater was exposed; pulse 80; complexion pale. To have beef-tea and quinine mixture.

October 6th.—Yesterday evening the patient, when going to bed, was suddenly seized with a fit, during which he was insensible, foamed at the mouth, and exhibited convulsive movements, more especially of the left leg. The attack lasted for some minutes, but there were two intermissions, of short duration, during which the patient ceased to "work," although he remained apparently unconscious all the time. This morning there is nothing remarkable in his appearance; his pulse is tranquil, and his appetite good; he has had no rigor or headache. His recollection of the attack last night is indistinct; was never subject to fits of any kind previous to the accident. Wound doing well.

October 7th.—Yesterday evening there was a repetition of the convulsive attack. It came on after supper, but was not so severe as on the former night. One of the other patients, who was in the ward when the seizure commenced, tells me that it came on quite suddenly, and without any warning or cry of any sort. The boy was sitting at the fire; presently his eyes became fixed and staring, and for a moment he appeared confused; next supervened convulsive movements of the jaw, and in an instant he dropped down insensible. In this state he continued for three or four minutes, with occasional spasms of the limbs and face, when he gradually recovered, and sat up.

October 10th.—This day, shortly after noon, I was summoned to see the patient. When I arrived at the hospital I found him recovering from one of the attacks. He complained of a heaviness in his head, and sick stomach. His skin was perspiring; pulse 80, irregular and soft. He had some recollection of how the fit commenced. He

first heard noises in his head, like the ringing of bells, attended with giddiness, when his sight left him, and he remembered no more. The wound was dressed in the morning, and presented nothing remarkable. He has no paralysis of sensation or motion anywhere; his pupils are a little dilated, but contract naturally when exposed to light; bowels open; urine pale and clear, density 1015; no albumen.

On the 12th, 13th, and 15th, the patient suffered from a repetition of the epileptiform convulsions just described, varying, however, in intensity and duration. All the seizures, it is to be observed, occurred in the evening or towards night, with the exception of two, and these happened at mid-day on the 10th and 13th. On the 13th he had a second attack, also at bed-time, in addition to the one which he experienced in the earlier part of the day; it was, however, slight and transient, and consisted merely of the premonitory ringing in the ears, giddiness, and confusion, attended with palpitation of the heart. He did not become insensible. The seizure on the 15th was not severe; it was the last.

October 17th.—This day, while dressing the wound, my attention was directed to a firm substance in the centre of the granulations. This I seized with a forceps, and extracted. It proved upon examination, to be a thin, sharp, and irregular fragment of the inner table of the skull. Subsequent to this there was no return of the convulsive attacks; the wound healed and cicatrized, and the patient left the hospital on the 30th, in perfect health. The cicatrix which remained was depressed, and at one point the pulsations of the brain were still slightly perceptible.

Case 2.—Compound depressed Fracture of the Skull.—Laceration of Dura Mater, and loss of Cerebral Substance.—Extraction of Depressed fragment of Bone.—Fungus Cerebri.—Recovery.

On Sunday, the 3rd September, 1854, I was requested to visit Caleb McElhenny, a boy of about 12 years of age, who had just received a severe injury of the head. Although I was unable to ascertain from an eye-witness the precise manner in which the accident occurred, nevertheless it was sufficiently clear, from the history which I received, that the patient had been thrown from a horse. He was found insensible on the road-side; marks of blood were discovered on a block of stone near where he lay; it was known he had been on horseback a short time previously, and the animal which he rode was subsequently found grazing in an adjoining field. I found the patient in the following condition:—Not altogether insensible. Although unable to speak or reply to questions, he was evidently conscious of what was passing around him. Surface pale and moist; extremities cold; pulse

86, feeble and small; pupils natural, and possessing their normal contractibility; right arm and leg paralyzed. The left side of head presented an extensive lacerated wound, and between its edges lay a quantity of cerebral matter, which also besmeared the adjoining hairs. Upon introducing my finger through the opening in the scalp, I found a portion of bone considerably depressed; it was also displaced laterally, so as to lie partly under the adjoining skull, and moreover appeared loose and isolated. By seizing its margin with a polypus forceps, I was able to remove it without difficulty. The fragment, which proved to be a portion of the left parietal bone, was irregularly oval in form; one of its edges (A), sharp as a knife, was formed almost exclusively of the inner table. Its long diameter measured a little more than two inches; its short, one inch. The woodcut shows



the exact size and shape of the piece of bone removed; the edge, marked A, was that which had penetrated the dura mater. The opening in the dura mater, through which the brain substance escaped, was about one inch and a-half in extent, and through it the cutting edge of the depressed portion of bone had penetrated, so as to lie embedded in the cerebral hemisphere. Having cleaned the wound, &c., and ascertained that no other portion of the skull deviated from its proper level, the edges of the former were approximated with adhesive plaster, and a double-headed roller carefully applied. The operative proceedings appeared to have no effect on the condition of the patient. Ordered three grains of calomel at night.

4th. This day the patient is quite conscious. When spoken to he nods his head, but is unable to articulate; puts out his tongue when directed, but the organ, when protruded, turns to the right or paralyzed side. The superficial muscles of this half of face have also lost their power, and the contraction of the orbicularis displays this remarkable condition:—the ordinary nititating action of the muscle is carried on synchronously with the one of the opposite side; nevertheless the patient is unable to close the eye by an *effort of the will*.^{*} Irritation of the conjunctive is followed by closure of the lids. Pulse 90; countenance cheerful.

^{*} It is evident that the influence of the true cerebral centre over the muscle was annulled, and that its action was exclusively controlled by the excitatory axis, or true spinal marrow of Marshall Hall. I attempted to excite reflex phenomena in the paralyzed extremities, but the experiment was not satisfactory.

Ordered black draught immediately, and three grains of calomel at night.

5th. Patient much in same condition. Bowels moved; slept well; tongue whitish, but moist; not much heat of skin, or thirst; pulse 90, firm *Mitatur sanguis ad uncias octo*. One grain of calomel and two of James's powder three times daily.

6th. Power of speech returning; can pronounce "yes" and "no" with tolerable distinctness; is unable to move right arm or leg, but there does not appear to be loss of sensibility anywhere, as he winces when the integuments of the paralysed extremities are pinched or compressed. Pulse 90, rather softer. Upon removing the dressings this day, the edges of the wound were found apart, and separated by cerebral substance mixed with minute particles of extravasated blood; the neighbouring scalp, moreover, was raised into an oval swelling, which pulsated distinctly. This swelling corresponded to the opening in the skull. The edges of the wound were again accurately brought together with stripes of adhesive plaster, and a firm compress of lint, supported by a double-headed roller, placed over the tumor.

7th. Edges of gums swollen, and marked by diphtheritic exudations; mercurial fœtor scarcely perceptible; continue calomel and antimonial powders; dressings not disturbed.

8th. Bowels moved frequently during the night; tongue white and dry; thirst increased. As the roller had shifted from its position, and the sticking-plaster appeared loose, they were removed, and also the compress. The latter was displaced by the pulsations of tumor, which had again become prominent, elevating the scalp into a well-defined convex swelling. The substance of the fungus projected through the wound, which was again open. The removal of the dressings appeared to give fresh vigour to the tumour, which, unrestrained by compression, throbbed violently, and in spite of every precaution extruded itself more extensively through the wound. It presented the same appearance of broken-down cerebral matter mixed with blood. I may here remark, that the scalp-wound did not correspond to the centre of the swelling, but lay along its base, nearer the sagittal suture, so that the uninjured soft parts covered the entire convexity of the tumor. This was a fortunate circumstance, as it enabled the compress to be applied with greater efficiency. The disorganized brain substance and blood which lay between the edges of the wound—now suppurating healthily—being removed, the compress was readjusted, and supported in the ordinary manner. Discontinue powders.

9th. Mercurial fœtor tolerably distinct; bandage, &c., in *statuo quo*.

10th. Removed the roller with caution, to examine the dressings, and as the compress appeared moistened with purulent discharge, it was quickly replaced by another of greater thickness. The adhesive plaster was not disturbed.

12th. Upon exposing the wound this day, its edges were again found apart, and the interspace filled with the detritus of brain substance and extravasated blood. The tumor had raised up the compress, and loosened the adhesive straps. As the short growing hairs prevented the sticking-plaster from properly adhering, it was found necessary to re-shave the scalp; meanwhile the tumor, although compression with the fingers had been kept up, rose more and more through the opening in the cranium, and beat with the diastolic impulse of an aneurism; the patient, at the same time, became quite excited; his face flushed, the vessels of the head throbbed, and the heart's action acquired greater strength and frequency. This erethism ceased with the reduction of the fungus, and the re-application of a thick compress.

13th. Patient remained quite tranquil since yesterday; no return of heat or flushing; slept well; pulse 80; skin natural.

15th. Dressings removed; no prominence of tumor, although the pulsations of the brain can be seen and felt through the scalp where the skull is deficient. Wound healing; its centre is still filled with softened brain, in small quantity; compress, &c., reapplied. Up to this date the patient's diet consisted, for the most part, of gruel, bread and milk, rice, &c.; he was now ordered, in addition, beef-tea.

17th. Improvement continues; wound healing rapidly; the situation of tumor is now occupied by a well-marked depression, corresponding to the opening in the skull, and over the space two orders of pulsations are distinctly visible—namely, pulsations synchronous with the heart's action, and slower and more undulating movements of elevation and depression, depending upon the respiratory acts. The whole area of the concave space becomes elevated when the patient coughs. For some days past he has been looking pale, perspiring at night. Two grains of sulph. quinine, and five drops of aromatic sulph. acid, three times daily.

It is unnecessary to pursue, from day to day, the further history of the case; it is sufficient to state that the wound gradually closed in, and that the patient first regained his power of speech, and next the complete use of his lower extremities, and lastly of the muscles of his arm; the forearm, however, is a little atrophied, and he has not perfect power of the hand and fingers. The circulation, moreover, in these parts is more languid than on the opposite side; this is evidenced by slight lividity of surface, comparative coldness, and liability to chilblains. At this date, 29 months since the occurrence of the accident, the situation of the lost bone is quite distinct, and the scalp continues depressed into the opening, greatly below the level of the surrounding parts; it has acquired, however, considerable firmness, more especially at the circumference of the space, over the middle of which only the pulsations of the brain are now perceptible.

Case 3.—Compound Fracture of the Skull.—One edge of the fissure depressed.—No Cerebral symptoms.—Non-interference.—Recovery.

On the 10th of October last, a boy named James Ewing, æt. 14, presented himself at the Letterkenny Dispensary. He had received a fall off a horse five days previously. On the right frontal region there was a lacerated wound, one inch and a-half in length; its edges were swollen and puffy, and the surrounding soft parts slightly œdematous. He was not stunned by the fall, nor had he at any time since the accident, sickness of stomach or headache. Pulse tranquil; tongue moist. I passed a probe into the wound; it touched the bone; the latter felt bare, and denuded of periosteum. A fissure, the extent of which I did not seek to ascertain, proceeded in a nearly transverse direction across the bone. One of its edges was distinctly depressed several lines. This was made evident by the extremity of the probe hitching against the irregularity offered by the other or level margin of the fracture. I prescribed for this boy small doses of calomel and James's powder. Water dressing was applied to the wound in the first instance, and subsequently simple ointment. It was healed in three weeks. The patient recovered without a bad symptom. His mouth was not affected by the powders, which were taken irregularly.

OBSERVATIONS.

Surgical opinion is still much divided respecting the treatment of depressed fractures of the skull, unattended with symptoms of cerebral compression. High authorities might be cited in support of practices diametrically opposite. The presence of an external wound communicating with the broken bone, is regarded by many surgeons of the greatest eminence as a complication of the most serious description, demanding in fact the application of the trephine in every case of depressed fracture, irrespective of other considerations. Other practitioners, of equal scientific knowledge and experience, are decidedly opposed to this doctrine, and never employ the trephine in injuries of the head, of whatsoever description, unless coma, paralysis, or other unequivocal symptoms of compression of the brain exist to a dangerous extent; and in support of the principle of non-interference in the absence of urgent symptoms, quote numerous examples of recovery, under circumstances almost hopeless, to demonstrate the wonderful power the brain possesses of bearing with impunity the pressure of depressed bone, and of even tolerating the presence of foreign bodies in its substance. Perhaps both these doctrines, pushed beyond the bounds of fair induction, have had too much of an exclusive influence on our practice and deliberations, leading, on the one hand, to unnecessary or even mischievous interference, and on the other, to an equally dangerous expectant treatment of cases where the patient's safety depended on the prompt application of the

trephine, and that here, as in the case of many other disputed questions in science, truth will be discovered where extremes meet. Why, in injuries of the head, should different principles influence our practice from those which direct our proceedings in other surgical accidents? or why should more definite rules be laid down for the treatment of a certain class of depressed fractures of the skull, than for the various other complicated injuries that tax the judgment and practical acumen of the surgeon? Take, for example, a case of severe compound fracture of the leg. Is the question of immediate amputation determined by the presence of any one complication? Is not every possible circumstance and contingency, pro and con, deliberately debated and weighed, before any fixed proceedings are decided upon or adopted? Nevertheless, the solution of the problem in the important accident under consideration, namely, depressed fracture of the skull without symptoms of cerebral lesion, is reduced to a simple formula by opposite authorities:—"If the injury be compound, elevate the bone," is one dictum; "wait for symptoms," the other. We are told that the operation of trephining, abstractedly considered, is proved by the result of certain cases* to be most dangerous, and therefore, it is concluded, should never be had recourse to, except under desperate circumstances. But the term "dangerous" cannot be applied to surgical operations, in a strict or exclusive sense, or without reference to the nature or degree of the disease or accident requiring their performance; thus, if any surgical operation exceeds in severity the requirements of the case, it becomes dangerous, in proportion to the amount of additional injury which it inflicts, but "desperate diseases require corresponding remedies," and so, in fractures of the skull, such as we are considering, the trephine may be needlessly employed, so as to add to the injury, and increase the danger already existing, or to render the state of the patient less complex by simplifying the nature of the accident, whether the latter be compound or otherwise. The three cases just detailed are not without interest, as bearing upon this subject. They were all cases of compound depressed fracture; they all occurred, remarkably enough, much in the same manner, and in boys of nearly the same age. In two of them no symptom of cerebral lesion whatever existed. In Case 2, I think I am justified in asserting that the external wound was a fortunate complication for the patient, as it enabled me, without hesitation or delay, to ascertain the precise nature of the

* I allude to Mr. Ramsden's fatal operations, performed upon some unfortunate individuals, if I recollect rightly, for the removal of a fixed pain in the head. But no fair objection can be urged against the legitimate employment of the trephine, grounded upon the result of these cases, which were, in fact, little short of experiments upon healthy individuals. In fractures of the skull, and other cases justifying the use of the instrument, severe injury has already been inflicted, or great danger exists, which, irrespective of the operation, perils the life of the patient.

accident, and to remove at once the loose fragment, which had lacerated the dura mater, and lay embedded in the brain. Although the patient was semi-insensible, the general symptoms were by no means severe, and had no solution of continuity existed in the scalp, I would not have felt myself justified in interfering, at least for some days, or until I had failed in removing existing symptoms by other means. The removal of the fragment would then have been effected under far less favorable circumstances. Although foreign bodies of a certain form have occasionally lodged quietly in the brain, becoming encysted, and ceasing to act as sources of irritation, surely the most ardent votaries of the *vis medicatrix* could scarcely hope, that in this instance such a substance as an irregular piece of bone, of considerable size, loose, and isolated from its connexions, could lie partly outside the dura mater, and partly embedded in the cerebral substance, without sooner or later exciting mischievous consequences; and further, had the fracture been simple, how could the portions of brain extruded from the cranial cavity, and lying outside the fibrous membrane, have been disposed of? Let us suppose the case to progress in the most favorable manner possible, and these must in time have undergone a process of softening and putrefaction, an incision would have been required, to discharge the fetid contents of the abscess, and thus at length after great hazard, the fracture would ultimately have become compound. I am warranted therefore in believing, that had no external wound existed in the first instance, justified as I would have been upon the dicta of the highest authorities, in not immediately interfering, the patient's life would have been in far greater peril. The successful application of pressure in restraining the growth and curing the fungus which sprung up, in this case, is a practical fact of some importance.

In Case No. 1, I was induced to elevate the bone, for the following reasons, namely: the form of the fragment, which was angular, the great degree to which its apex was depressed, its mobility, and the fact of the internal table being extensively broken, which was ascertained by the probe, and I believe the sequel of the case may fairly be taken as a proof of the propriety of the practice adopted. The occurrence of convulsions, and their subsidence upon the discovery and extraction of a sharp fragment of the inner table, are circumstances of unusual interest and importance; and I am warranted in supposing that had I acted in accordance with the doctrines of those who "wait for symptoms," in such cases, the unnatural position of the depressed bone (supposing the patient to recover from the immediate consequences of the accident) would have occasioned the worst form of epilepsy, as one of its remote effects.

The last case, although properly included in the category of compound depressed fractures, was, really, but a simple fissure of the skull, with one of the margins slightly sunken below its normal

level. In this case, due weight was given to the doctrine of non-interference, and I am happy to say that I waited for symptoms which never manifested themselves; the patient never complained even of head-ache, and made an excellent recovery. This was a case of compound depressed fracture, in which I cannot help thinking that the use of the trephine would have been little short of criminality.

In conclusion, I would submit, that in determining the question of operative proceedings in depressed fracture of the skull, without urgent symptoms of cerebral lesion, the following conditions, in addition to the important complication of an external wound, deserve the serious consideration of the surgeon:—The size and form of the depressed fragment, its degree of depression, its looseness, isolation, and mobility; the state of the internal table, when this can be determined; the existence and amount of comminution, and the state of the dura mater and brain.

CONTRIBUTION OF THE ARTS TO SURGERY.

By BEN. WILLS RICHARDSON,

Fellow and Member of the Court of Examiners of the Royal College of Surgeons in Ireland.

An instrument, known in the arts as the Archimedean Screw Drill, has been used by Dr. Hutton for some years, to discharge abscesses of bone; likewise, to make the necessary openings for the wires and ivory pegs in the treatment of ununited fractures.

Within the last few months, a very great improvement has been made by the manufacturer in the Archimedean drill, which, it appears to me, renders it far superior to those hitherto in use.

The Improved Drill* as seen in the accompanying illustration, combines the convenience and advantages of the ordinary drill on the Archimedean principle, with a more rapid and continued motion of the drill in *one direction only*, which is attained by the addition of a small German-silver fly-wheel, B.

The driving handle is worked up and down the screw part of the instrument, thus giving it the reciprocating motion; while, by a simple arrangement in the centre of the wheel, its rotation in *one direction* is secured.

This drill has a most steady motion, and cuts with the greatest facility, which leads me to think, it might also be impressed into the practice of Surgery.



* Sold by Messrs. J & J. Booth, 35, Golden-lane.

ABSCCESS CONNECTED WITH HIP-JOINT DISEASE,

OPENING INTO THE URINARY BLADDER.

To the Editor of the Dublin Hospital Gazette.

SIR,—A very interesting case of the above has lately come under my notice, and I forward the particulars for insertion in the GAZETTE.

The patient, Thomas Gallagher, a labourer, aged 23, has been suffering upwards of two years, under Hip-joint disease, originating in synovitis, caused by "a twist" of the joint, which he neglected at the time. He had been in the North Union Workhouse for twelve months, and left in April last. On the 29th of last month, I saw him for the first time; he presented a condition of debility and emaciation beyond description, and the right hip-joint was enveloped by an enormous abscess, skin extremely tense but not discoloured. The femoral portion of the extremity reminded me forcibly of the shape of a club, such as is used in a gymnasium, the bulbous extremity corresponding to the hip, and the handle to the knee below. The agonizing suffering of the man, produced by the tension of the tumour, induced me to propose opening the abscess; but the scruples entertained by him, as well as the wretched condition he was in, without nourishment or any comfort, made me hesitate. He would not go to hospital.

The man remained much in the same state until the 12th instant, when he called my attention to the contents of the utensil, which contained nearly a quart of purulent matter. He stated, that during the night he felt a sharp pain passing from the navel downwards towards the pelvis, with a "sensation as if something had burst inside," and that, towards about five o'clock in the morning, he was disturbed by purulent matter passing from the urethra in large quantities. The tumour had become soft and flaccid, but not empty. Since that period, he has discharged purulent matter copiously by the urethra, and he states that, before doing so, he has the same sensation of fullness of the bladder which precedes the evacuation of urine. At intervals clear transparent urine appears, but this I have not seen.

As to the precise course the purulent matter took in this singular case, it must at present be a point of discussion for the anatomist. It may have burst through the acetabulum into the pelvis, and thus reached the bladder; or it may have passed backwards, through the Ischiatic notch; or it might have gained admission to the pelvis by the thyroid foramen; or, lastly, by following the psoas up under Poupart's ligament, and then burrowing down near the ilio-sacra lymphysia. It certainly did not take a perineal course to the urethra, for there was no fullness or uneasiness in that direction; and I apprehend, if it had been such a case, and burst into the urethra, the sphincter

vesicae would have prevented its course backwards to the bladder, and there would have been a constant oozing from the urethral orifice; I therefore assume that the abscess communicated with the bladder, and from thence the matter was discharged per urethram.

Should future opportunities throw further light on this interesting case, I shall apprise you.

I am, sir, your obedient servant,

HAMILTON LABATT, A.B. F.R.C.S.I.

1, Upper Fitzwilliam-street,
January 20th, 1857.

NOTE.—The above case had proceeded to dislocation upwards and backwards.

PATHOLOGICAL SOCIETY OF DUBLIN.

A meeting of the Pathological Society was held on Saturday, January 10,

Dr. LEES, V.P., in the Chair.

Fracture of the Skull.—Hernia Cerebri.

Professor R. W. SMITH, in the absence of Mr. ADAMS, exhibited a specimen of Fracture of the Left Parietal Bone. It was compound and comminuted. The bone was driven into the brain, leaving an aperture as large as a shilling, and almost as regular as if the piece had been removed by the trephine; the dura mater was separated from the bone around the opening, and the corresponding parts of the brain were pulpy and mixed with blood. There was a general increase of vascularity both in the brain and its membranes, and a collection of serum in the ventricles. The injury was inflicted by a blow with the end of a poker, and was at once followed by paralysis of the right arm and leg. The patient, a man, æt. 25, was admitted into the Richmond Hospital, under the care of Mr. Adams, five hours after the receipt of the blow. He was supported into the hall, leaning upon two men, and trailing after him the right leg. There was a wound about an inch in length over the left parietal bone, near the sagittal suture, and brain was seen mixed with the hair. The motions of the brain, synchronous with the pulse at the wrist, were very visible. During inspiration the edges of the wound were drawn in, and the brain depressed; during expiration the cerebral substance protruded the wound. The mental faculties were unimpaired, and there was no affection either of speech or respiration. The sensibility of the paralyzed limbs was perfect, but their muscles were flaccid. The countenance was placid and undisturbed; there was no paralysis of the sphincters; the pulse at the wrist of the paralyzed arm was weaker than on the opposite side. Three hours after his admission, a small quantity of blood was taken from his arm, but fainting and vomiting were the result, and during the vomiting, portions of the brain were forced out through the wound;

shortly afterwards he was seized with a remarkable convulsion of the paralysed side; the muscles of the face and neck participated, however, in the convulsive action; the mouth was drawn up to the right, or paralysed side, and the eye upon that side was rolled in every direction, and retracted, the opposite eye remaining quiet, and under the control of the will. The convulsive movements commenced above, the arm being seized before the leg; the contractions of the muscles were lively but not strong; the fingers and toes were flexed, and the head involuntarily raised from the pillow. Before the end of the fit, he remarked, in a distinct tremulous voice, "my limbs are becoming again palsied." This was at least one minute before the convulsion ceased. During the attack the pulse rose to 130, and the body was covered with a cool perspiration. The convulsions occurred at uncertain intervals during the night; between them he slept a little; he was thirsty, but drank in any quantity caused vomiting, during the act of which he always lost some portion of the brain. Upon Wednesday morning (the morning after his admission) nine fragments of bone were removed with a forceps. He remained without the occurrence of any new symptom till Saturday, when a fungus (as it is called) began to protrude from the wound, at first small, and of a light colour; it quickly enlarged, and became dark with blood. When this tumour reached its height, symptoms of compression gradually accumulated. At first there was lethargy or coma, from which, however, he was easily roused; the pulse was slow and laboured, and the alternations of paralysis with convulsions ceased. The symptoms of compression continued varying in degree during Sunday, Monday, and Tuesday. On Monday evening his face became flushed and his pulse rose, shortly after which a copious hemorrhage took place from the tumour, and his countenance suddenly became pale; the upper surface of the tumour was deeply fissured, and from the bottom of the clefts, blood, of an arterial colour was welling up in great quantity. He was nearly speechless, but seemed to understand the questions put to him; his answers died away in indistinct murmurs. The tumour, of the size of half an orange, was cut away, and the bleeding arrested by the use of turpentine; it consisted of brain and blood, and its smell was very offensive. Early on Tuesday morning blood began to trickle down the cheek, and then a dark fungus appeared, equal in size, and similar in aspect to that which had been removed. On Thursday morning (tenth day) his pulse was 130, respiration 62; he had singultus occasionally; his face was expressive of fatuity; the power of vision appeared to be lost; there was slight strabismus, and the right cheek flapped in and out during respiration. Occasionally the muscles of the eye were affected with spasmodic twitches, during which the eyeballs were strongly turned to the right side. He was unable to swallow, moaned continually, had sub-

sultus, and was frequently catching at imaginary objects. In the evening he died.

Diseased Knee-joint.—Abscess in Femur, and Necrosis.

Mr. HAMILTON said, he was asked to examine a young gentleman's leg, with the view of ascertaining whether amputation were advisable. The patient was 14 years of age, and had suffered from disease of the right knee for ten years. It became painful and swollen after a fall, and rapidly went into suppuration, with such constitutional disturbance, that amputation was then recommended. He gradually got better in his general health, and the abscesses discharged less matter, but have never ceased entirely since; thus there has been a drain, more or less profuse, for ten years. So injuriously did the irritation of this severe local disease act, on a constitution originally highly scrofulous, that at seven years old, three years after its first commencement, he had an attack of disease of the brain, in which he had convulsions, and lay insensible for three days, and was given over by the late Dr. Graves. He is very delicate, and though he goes about with a crutch, he has no energy, and is very deaf.

The leg was found ankylosed to the femur, and flexed backwards, at more than a right angle, admitting of some very limited motion, shewing the ankylosis to be fibrous; but it was immoveable, as far as straitening went, and the ham-string tendons did not become tense or resisting when an attempt at extension was made. The foot and leg were small and withered-looking. There were three fistulous openings, two in the popliteal space, and one in front, about three inches above the joint, and leading down towards it, the probe at some distance feeling the rough surface of diseased bone. These discharged, at times freely, brownish yellow pus. He kept the thigh rather flexed on the pelvis.

It was clear that the leg was not only perfectly useless, but in the way, in its present contracted withered condition, and that the irritation of some diseased portion of bone kept up a morbid state of the constitution. This disease of the bone extended some distance up the femur, which was expanded at its lower fourth, and very tender on pressure. It was not a case for any attempt at straightening the limb by division of the ham-string tendons, they not becoming tense, as they would if they were the resisting powers to extension; nor indeed would the diseased state of the lower end of the femur justify any attempt at forcible extension; Mr. Hamilton, therefore, felt no hesitation in advising amputation; and, assisted by Professor Smith, he removed the limb, which he now exhibited.

"It will be observed, that though there is complete flexion of the tibia on the femur, that the head of the tibia is not dislocated back on the condyles of the femur, nor is the foot rotated outwards,

which is the ordinary condition of the limb, when ankylosis has taken place in a flexed position, in consequence of scrofulous disease of the knee, as you see it in this cast, taken from a boy in whom I propose to divide the ham-string tendons, and use a certain extent of forcible extension, to be followed by prolonged stretchings, by means of a proper apparatus. Here you see the leg flexed to near a right angle, the lower end of the femur projecting over the tibia, which is drawn back and rotated outwards, with the foot pointed downwards and outwards. In cases so apparently similar, what is the reason of this difference? It is shewn by the examination of the joint. There are fibrous adhesions between the articular ends of the femur and tibia, not very extensive; there are irregularities on the surface of the cartilages, where former ulcerations had existed, leaving irregular map-shaped depressions, nearly down to the bone in some cases, and completely so in others; the crucial ligament, though fleshy and granular, still exists; in fact, the interior of the joint does not exhibit the traces of that total disorganization which we commonly observe in such cases, and hence the absence of that amount of displacement which we ordinarily observe in the ankylosed leg. The most serious disease is in the lower end of the femur, which, at the condyles, is nearly twice the natural size, of a livid colour, the periosteum easily removeable from the bone, and a large long abscess between the condyles, with a small piece of isolated deadbone in the centre; the cavity lined with a thick soft membrane, communicating on one side with the joint, and externally, more or less circuitously, with the fistulous openings. It is most likely that this was the point of origin of the disease; the bone, after having been struck by the fall, took on acute scrofulous inflammation and supuration, and finally extended to the interior of the joint itself. I may observe that he has gone on very well since the operation; his general health remarkably improved, and he has quite recovered his hearing."

NOTES OF RECENT OBSERVATIONS IN PHARMACY AND THERAPEUTICS.

By Dr. ALDRIDGE.

Treatment of Dropsy.

In the October numbers of the *Bulletin de Therapeutique* are contained some observations on the treatment of certain forms of anasarca. Dr. Thibaud, of Nantes, finds great benefit to be derived from the employment of large doses of acetate of potassa (an ounce, or more, during the day,) in cases of anasarca, and ascites following ague, and apparently arising from alteration of the blood. In this country physicians have comparatively little experience of ague; but anasarca, from blood disease, is by no means rare. Leaving out

of account the familiar example of chlorosis, in which oedema of the ancles, and even more extended anasarca, is a common symptom, many of our readers may recollect instances, in which broken health and altered complexion were complicated with more or less oedema, without any evidence of kidney, liver, or heart obstruction; and we remember some cases of this kind which were evidently, in some way, connected with malarious exposure. It will be something new if it is found that the proper way to enrich the blood, under such circumstances, is best effected by increasing the aqueous excretions—by taking water from the blood, in place of adding iron to it.

There is also given a case from the practice of M. Aran, in which anasarca and ascites, arising from congestion of the liver, were removed by considerable and continued purgation. The reporter takes special pains to shew that the urine in this case was not coagulable, thus apparently insinuating that, if it had, the event would have been different. This is an assumption which we wish to declare against. The presence of each and all of the symptoms of granulated kidney do not entitle us to despair. We recollect, on one occasion, being requested by a general practitioner in this city, to visit a boy supposed to be labouring under hydrocele. A surgical student had already attempted to tap the scrotum, but had only succeeded in causing the escape of a few drops of liquid. Upon examination, we found some oedema of the ankles, and the urine highly albuminous and alkaline, effervescing violently with nitric acid. We reported the true nature of the case to our friend the apothecary, and saw no more of the patient for some months, when we accidentally met him, looking quite well; and upon inquiry ascertained that he had been well purged with compound powder of jalap, which had cured him. In this instance there was no suspicion of recent scarlatina, or other exanthematous disease. We may here notice that the situation that may become the starting point of anasarca depending on kidney disease, is very variable. We remember an instance in which, after abortion, it was confined to one leg, tense, painful, and resisting to pressure, without pitting, and might very readily be mistaken for phlegmasia dolens. Another example of the occasional amenability to treatment of dropsy, accompanied by dry skin and coagulable urine, occurred some years ago, in a young man in our employment. He was given large doses of nitrate of potash, a drachm three times a day; when, rapidly, the anasarca and ascites became absorbed, the skin acquired moistness, and the urine lost its coagulability. He subsequently became a railway porter, and we had the opportunity of knowing that, at least for a year and a half, there was no return of the disease.

After all, let us not be too certain that it was the compound powder of jalap in the one case, or the nitre in the other, that cured these patients.

On one occasion, having charge of a dispensary for the poor, a woman brought to us a child suffering from anasarca, after scarlet fever. The little creature was very feverish, her skin intensely hot and dry, and her urine albuminous, smoky, and alkaline. We prescribed a combination of cream of tartar and tartar emetic, and ordered dry cupping to the loins. In a few days the mother returned with her child, greatly improved in every respect, and it was with no small complacency we remarked, "well, my good woman, your little daughter is much better." "Oh yes, thank you," said she, "and so is her little brother." "Why, what of her brother?" we exclaimed, "we have not heard of him before." "Ah," said the mother, "he was so bad in the same way, that I did not like to trouble you with him, so I left him to God!"

Valerianate of Ammonia.

This substance appears to attract considerable attention, as a remedy for neuralgia, and has been the subject of a somewhat unseemly squabble among certain members of the Parisian faculty; but with this we have no concern. When we first saw a notice of it in the periodicals, we could find no mention of its mode of preparation; and as the dose spoken of was by spoonfuls, manifestly of a solution of unknown strength, we were thrown on our own resources to prepare it. Accordingly, we mixed equivalent solutions of valerianate of zinc and carbonate of ammonia, and removing the carbonate of zinc thus formed by filtration, evaporated the filtered liquid, and finding that it would not crystallise, dried and powdered the residue. We found this to be a very expensive process, the product being considerably less than what theory would lead one to expect. M. Laboureur being, like ourselves, without a guide, has also been experimenting; but the process which he adopted was to pass dry ammoniacal gas through mono-hydrated valerianic acid, when he obtained a product perfectly white, and confusedly crystallised. Its composition is, one equivalent of valerianic acid, one of water, and one of ammonia; or, one equivalent of valerianic acid, and one of oxide of ammonium, according to the theory you adopt. It is very deliquescent; when placed on water or alcohol it gyrates rapidly, according to the custom of the valerianates. It has a mixed odour of valerianic acid and of ammonia, but soon loses the latter when put in an exhausted receiver. Its reaction is slightly acid, even when dissolved in water or alcohol. Ether dissolves it, forming an oily liquid; so do the oils, although more slowly. Oil of turpentine gives it the appearance of transparent plastic fat. Heat partially decomposes it, and what remains recrystallises by cooling. The acids decompose it, liberating the valerianic acid, which swims on the surface of the liquid.

It appears now, however, that the medicine first introduced to the notice of the profession by M.

Déclat, is a solution of valerianate of ammonia of a fixed strength, which has long been prepared by M. Pierlot, a pharmacien in Paris, and which has been extensively exhibited to the epileptics, both at the Salpêtrière and the Bicêtre. M. Pierlot has at length published his formula, which is as follows:—

Distilled water, 32 drachms,
Valerianic acid, 1 drachm,
Sub-carbonate of ammonia, q. s.

To neutralise the acid, add

Alcoholic extract of valerian, 2 scruples.

His object in the construction of this formula, he says, was to obtain a concentrated solution of all the constituents of valerian root, in a condition as little disagreeable as possible. He maintains that valerianic acid pre-exists in the root, and is an educt, not a product, as hitherto presumed.

However that may be, there seems to be some virtue in the medicine. Dr. Desmarres describes a case of intense choroiditis, in which, after considerable depletion and low diet, severe paroxysms of neuralgia supervened. Doses of a grain and a half of sulphate of quinia seemed merely to exasperate the pains. He then tried Pierlot's solution of valerianate of ammonia, in doses of three coffee-spoonfuls per diem; and the first day the pains so far remitted, that the patient obtained a tranquil sleep, and in a few days more he quite recovered his appetite. Dr. Tufnell, Professor of Military Surgery in this city, has also tried it in some cases, and found it eminently successful.

Glucosuria of Nurses.—Treatment of Diabetes by Iodide of Iron.—Formula for Oil of Iodide of Iron.

Dr. Hyppolyte Blot has brought before the Academy of Medicine the results of some researches directed to determine the presence of sugar in the urine of women secreting milk. It appears that sugar is present, physiologically, in the urine of all women in labour, of all nurses giving milk, and of about one-half the pregnant women. He proves these facts by the reduction of copper, Moore's alkaline test, alcoholic fermentation, and lastly, by the deviation to the right of the plane of polarization. M. Blot considers that he has ascertained that lactation has a constant relation to the amount of sugar in the urine; that when the former is most abundant the latter is in greatest quantity; that when disease arrests the former, the latter diminishes, or even disappears. Its presence in pregnancy is in relation to the development of the breasts. This phenomenon is not peculiar to the human subject; M. Blot has also found sugar in the urine of nine milch cows which he examined. Every day's experience tells us, that the presence of sugar in the urine is not the purely pathological phenomenon which it has heretofore been considered. We long ago expressed our belief that it is always present in this secretion, although usually in very minute

quantity. We often meet with it for a transient period, even in comparatively large proportions, in various diseased conditions; and its relations to the process of gestation might have been before now guessed, since our discovery of its presence in the whites of eggs.

A late case has been published by Dr. Burguet, confirmatory of the advantages stated previously by MM. Martin Solon, and Combette, to be derivable from the exhibition of large doses of iodide of iron in diabetes mellitus. The latter writers state that they have given the iodide in doses as high as a gramme (about 15 grains). From the benefit stated sometimes to arise from the use of fatty matters in this disease, we may find this the best place to mention the formula for an oily solution of iodide of iron, recommended by M. Adolphe Schaeffele:—

Iodine, 34 grains.

Iron-filings, $7\frac{1}{2}$ drachms.

Almond oil, 25 ounces.

Sulphuric ether, 2 drachms.

Triturate rapidly the iodine and iron-filings; then introduce into a flask, into which you pour the ether. By gentle agitation a chemical action soon commences, at first deeply coloured from free iodine; but this disappears in proportion as the latter becomes absorbed into protoiodide of the metal. This is then to be added to the oil, and heated in a porcelain capsule placed on a water-bath, until the ether is dispelled. The oil is lastly to be filtered, to remove the surplus iron. This is a mild preparation, five drachms containing only about a grain of the protoiodide.

Employment of Carbonic Acid to provoke Premature Labour.

The Germans have a strong opinion of the virtues of carbonic acid in stimulating the menstrual function and combating sterility. At all the aerated spas one hears marvellous stories of the efficacy of the various brunnens in these respects. Dr. Simpson, of Edinburgh, recently communicated to the Obstetrical Society of that city the report of a case in which premature confinement at the eighth month seemed to have been induced by repeated applications of this gas, and which effect he was inclined to attribute to the mechanical distension produced by the injection of the gas probably detaching the membranes. M. Scanzoni, prompted by an observation of M. Brown-Sequard, who had demonstrated that carbonic acid gas provoked, by its contact, contraction of the muscles of organic life, and that the genital organs, a long time exposed to its action, became the seat of intense congestions—conceived the idea of bringing on, through its influence, in a fit subject, *accouchement* before the time.

A woman aged 26, a primipara, entered the Maternité at Wursburg, the 28th of January, 1856, in about the seventh month of her preg-

nancy. It is unnecessary to enter into the details which convinced M. Scanzoni that her life would be the forfeit of permitting her to proceed to her full term. Suffice it to say, that he resolved to hasten matters, and accordingly had recourse to the following expedient. He invented an apparatus, consisting of a kind of Wolfe's bottle, with two necks; the one fitted with a funnel having a tube sufficiently long to reach nearly to the bottom of the bottle; the other with a glass tube continuous with a long flexible and elastic pipe, adapted for the application of the gas. Having first introduced into the bottle—which had the capacity of about a quart—a sufficiency of bicarbonate of soda, he arranged the different parts of his apparatus in relation to his patient, and by pouring acetic acid through the funnel, could, whenever he pleased, cause carbonic acid gas to become evolved, and blow against the os-uteri. In this manner he applied the gas, on the 2nd of February, at eight o'clock, p.m., for 20 minutes; on the 3rd at eight in the morning, for 25 minutes, and again at the same hour in the evening, for half-an-hour. On the 4th the process was repeated, during half-an-hour in the morning and the same period in the evening; on the morning of the 5th a similar application was again made. The sensations experienced by the patient were those of a disagreeable sensation of painful pricklings, succeeded by darting pains about the navel. On the evening of the second day the vaginal portion of the neck was found to be sensibly softened; during the third day the neck became dilated, so that the inferior segment of the ovum could be felt, and towards evening some marked contractions of the uterus were perceptible to the hand placed on the abdomen; on the fourth day the orifice had dilated already in the morning to the size of a two-franc piece; the vaginal secretion had notably augmented; about noon regular labour-pains commenced; at half-past six the membranes burst; and in another hour she was delivered of a living infant, weighing about 47 ounces.

Amylene as an Anæsthetic.

Amylene is a colourless liquid, of low specific gravity, which was discovered by M. Balard, in the year 1844. He prepared it by distilling fusel oil with chloride of zinc. Its density is 0.659; it is very volatile, boiling at 102° F., and the specific gravity of its vapour is 2.45. Its composition is 10 atoms of carbon and 10 atoms of hydrogen, and it bears the same relation to fusel oil that olefiant gas bears to ordinary alcohol. It is inflammable, and burns with a brilliant white flame. It is soluble in alcohol and ether in all proportions, but very sparingly soluble in water. Its odour somewhat resembles coal naphtha.

This liquid has been latterly employed by Dr. Snow as an anæsthetic. He uses it in the same way as chloroform or ether, by causing its vapour to be inhaled.

Having ascertained its influence in producing insensibility to pain in animals, and subsequently in his own person, he next tried it at King's College Hospital, on patients who required to undergo various operations, and has thus determined its efficacy in 21 cases. In a paper read before the Medical Society of London, and reported in the *Lancet*, he states that the relative advantages of amylene may be summed up as follows:—In regard to its odour, it was more objectionable than chloroform, but much less so than sulphuric ether. In the amount which sufficed to induce insensibility it was also intermediate between these two agents. In regard to its pungency, it had a great advantage over both ether and chloroform, being much less pungent than either of them. On this account the patient could always begin to inhale the amylene of full strength within half a minute, and the operation might generally be commenced within three minutes. It had an advantage in preventing pain with a less deep stupor than was occasioned by the other agents; and in the ready waking and recovery of the patient it had an advantage over chloroform, and a still greater advantage over ether. The almost entire absence of struggling and rigidity in the use of amylene is another advantage it possesses; and the greatest advantage of all, if it should continue to be met with, is the absence of sickness from its use. The pulse is increased in frequency and force during the inhalation of amylene, to a greater extent than happens with chloroform; the respiration, also, is very often accelerated—about as often as in the inhalation of ether, and more frequently than with chloroform. It does not produce any unpleasant increase in the flow of saliva. The quantity required to be inhaled is the vapour from about three or four fluid drachms, and that at the rate of about a fluid drachm a minute.

Sulphate of Zinc as a Caustic.

Professor Simpson has conferred an additional benefit on medical science by pointing out the advantages of sulphate of zinc as a caustic. We quote, from the *Medical Times and Gazette*, extracts from his observations on this substance:—“Sulphate of zinc is a drug extensively and daily employed by medical men in solution, in the form of collyria, of lotions, of injections, &c. No writer, however, has, as far as I am aware, hitherto pointed out, that when applied as a fine powder to an open and diseased surface, sulphate of zinc acts as one of our most powerful and manageable caustics. In using it for this purpose, I have always employed it dried or anhydrous, and finely levigated. Sometimes I have applied it in the form of a simple powder, sometimes in the form of a paste, made with glycerine, and sometimes as a strong ointment. To work it into a paste, about a drachm of glycerine to an ounce of the dried powder is required; and in this form it keeps for any length

of time, ready for use. A caustic ointment may be formed by pounding together two drachms of axunge with an ounce of the dried sulphate of zinc. When used in the form of a powder, paste, or ointment, to an open or ulcerated surface, the part to which it is applied is rapidly destroyed to a depth corresponding to the thickness of the superimposed layer. The slough, eschar, or devitalised part is of a white colour, and usually separates on the fifth or sixth day, leaving behind it (if the whole morbid tissue is removed) a red, granulating, healthy, and rapidly-cicatrising wound. I have sometimes seen the edges of the wound already more or less puckered or contracted at the time of the separation of the eschar. The white slough or eschar itself shows no tendency to chemical or putrefactive decomposition, but is firm in texture, and free from taint or odour. If we apply the sulphate of zinc in any case of malignant or semi-malignant ulcer or deposit, it will require to be repeated immediately after the first or preceding eschar separates, provided any yellow or unhealthy tissue remain at the bottom or in the sides of the wound, or if the surrounding hardness is not yet quite dispelled. After the last eschar is removed, the remaining wound or sore will rapidly heal up, under any common applications, as black wash, astringent lotions, water dressing, &c. Sulphate of zinc, like chloride of lime, will not act as a caustic where the epithelium is entire, or unless it be applied to a broken or open surface. “The advantages of the sulphate of zinc, as compared with other caustics, are, therefore, in general terms:—1. Its powerful escharotic action. 2. The rapidity of its action. 3. Its greater simplicity and manageableness. 4. Its facility of application. 5. Its non-tendency to deliquesce or spread. 6. Its perfect safety. And 7. I believe I may add its efficacy.”

Dr. Wilde has shown us at St. Mark's Hospital, a case of *lupus erodens* attacking the orbit, to which he has applied this caustic, and in which its effects, as far as they have yet proceeded, seem to justify the foregoing encomiums.

BELLADONNA IN MERCURIAL SALIVATION.—Dr. Höring speaks in warm terms of the remarkable success attending the employment of this substance as recommended by Erpenbek. In two cases of peritonitis, in which mercurial salivation was induced, half a grain of the powder, given twice daily, soon dissipated all ill effects.—*Schmidt's Jahrb.* B. 92, p. 173.—*Med. Times and Gazette.*

TREATMENT OF ITCH.—After the trial and comparison of the various modes of treatment, M. Bourguignon accords the preference to the following formula:—Glycerine, 50 drachms; finely powdered sulphur, 25 drachms; 2 yolks of eggs; and tragacanth powder, q.s.; adding essences to mask the smell.—*Union Médicale*, No. 156.—*Medical Times and Gazette.*

FALLING-OFF OF THE HAIR.—Dr. Landerer considers it an error to mix substances intended to strengthen the hair in oils or fatty bodies, in which they are not soluble, and are so enveloped that they can exert no influence upon the relaxed skin. Thus 5 grains of quinine taken internally, or 10 grains used in a lotion endermically, will exert more influence than half an ounce used in an ointment. He has found great benefit from rubbing a watery solution of tannin into the roots of the hair. The modern Greeks employ a decoction of the root of the *Atractylis gummifera*, the *chamaleon leucos* of Dioscorides.—*Buckner's Receptor*, 1856, No. 8.—*Med. Times and Gazette*.

PROFESSOR SIMPSON, of Edinburgh, has received from King Oscar of Sweden the knighthood of the Royal Order of St. Olaf.

Correspondence.

We regret much that a foolish letter in reference to Mesmerism, by an anonymous writer, was inadvertently admitted into our last issue. We now only allude to the subject, to request Dr. O'Brien of Calcutta (on whose very interesting paper it might be supposed to reflect) not to be at the trouble of noticing or replying to it.

To the Editor of the Dublin Hospital Gazette.

SIR,—I do not agree with your Correspondent A. R., that it would be either *interesting or satisfactory* to have before us a comparative statement from the records of the Calcutta Hospital, as to the result of Dr. Esdaile's operations. It is within my knowledge, that the mortality after operations in Dr. Esdaile's time far exceeded the number mentioned; but I cannot see what advantage is to be gained by calculating the number who have survived operations after having been subjected to certain processes of mesmerism, when it is well known that the cases, from which that calculation is to be made, were selected not for the intensity of the disease or the severe nature of the required operation.—I am, Sir, your obedient servant,
A. G.

Jan. 19th, 1857.

To the Editor of the Dublin Hospital Gazette.

SIR,—Perhaps some of the many subscribers into whose hands your valuable Journal passes, may be able and willing to solve a difficulty for me, by letting me know the derivation and meaning of the word "Noma." I meet with it at page 332 of Erichsen's work on the Science and Art of Surgery, where one sees, from the context, that it is a name given to some gangrenous disease. I remain, Sir, yours,
MEDICAL STUDENT.

QUICK AND PAINLESS FORMATION OF ISSUES.

To the Editor of the Dublin Hospital Gazette.

SIR,—In answer to your correspondent, on the subject of Issues, I would recommend the use of intense cold, either to prevent the pain from some of the powerful caustics, or from immediate incision of the skin. The latter is the quickest mode and the best. After Anotising a portion of skin of about the size of half-a-crown, pinch it up with a forceps, and cut off the fold, leaving a sore of the diameter of a shilling, which is converted into a permanent ulcer by the usual means. I am, Sir, yours truly,
CHIRURGS.

Communications have been received from Dr. Connolly (London), Dr. Tucker, Dr. Sawyer, Dr. Johnston (Belfast), Dr. Jennings, Dr. O'Connor (London), Dr. O'Donovan, Dr. Monahan, Dr. Mansfield, Professor Smith, &c. &c.

We have been obliged to hold over until our next number the Reports of the proceedings of the Belfast Pathological Society, and other communications.

NOTICE

TO SUBSCRIBERS AND CORRESPONDENTS

The management of the Commercial Department of the DUBLIN HOSPITAL GAZETTE has been handed over to Messrs. BROWNE & NOLAN, 21, Nassau-street, Dublin, who will henceforth print and publish it; to whom all subscriptions are in future to be paid, and all communications for the Editor addressed.

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ON THE MECHANISM OF MUSICAL MURMUR IN THE HEART.

By Dr. CORRIGAN,

Physician in Ordinary to the Queen in Ireland, Physician to the Whitworth and Hardwicke Hospitals, &c.

To the Editor of the Dublin Hospital Gazette.

SIR,—You will oblige me by inserting in your next number the enclosed note from Dr. CORRIGAN. I consider it to be a very valuable commentary on the case of "Perforation of the Aortic Valves—Loud Musical Murmur," among my Clinical Reports in your last issue. I feel also that it would be an injustice to the profession to withhold from them any remarks on permanent patency of the aortic valves, or its consequences; which have emanated from him, to whom we are indebted for all our knowledge of that disease.

I am, sir, yours, &c.,

J. T. BANKS.

4, Merrion-square, West,
Feb. 4th, 1857.

MY DEAR BANKS,—I have more than once read over, with great interest, in THE DUBLIN HOSPITAL GAZETTE, of 1st instant, your Clinical Report and observations (p. 33), headed "Perforation of the Aortic Valves—Loud Musical Murmur."

I presume to write to you on the subject, because I think, after a most careful perusal of the case, that the diagnosis you made, during life, was fully borne out by the *post mortem* examination, viz., that "the probable cause of the musical note was a vibrating tongue;" and I must take your own part against your own correction of yourself, where you would, from the necropsy, modify or depart from your diagnosis. Your contribution is so valuable in advancing our powers of diagnosis, and the report of the case is so extremely accurate, that I cannot resist the temptation of making an analysis of it, in support of your diagnosis.

I will take the negative and positive facts in succession. The question to be determined is, what was the cause of the "loud musical murmur" or

musical note, so loud as "to be heard at some distance from the chest?" There were three principal pathological alterations present in your case, viz.:—1st. A cribriform state of the aortic valves. 2nd. An atheromatous condition of the aorta. 3rd. Three little rudimentary valves in the ventricle, about a quarter of an inch distant from, and beneath the mouth of the aorta, resembling closely in appearance the semilunar valves.

We have then, first, the negative evidence of there being no connexion between the musical murmur and two of the above pathological alterations, viz., the cribriform state of the valves, and the atheromatous condition of the aorta; for it is very common to meet those pathological states either separate or combined, in cases of "permanent patency of the aorta," without the "loud musical murmur." In fact, those pathological alterations are very common, and the "loud musical murmur" is very rare. We cannot, therefore, I think, admit of any connexion between them.

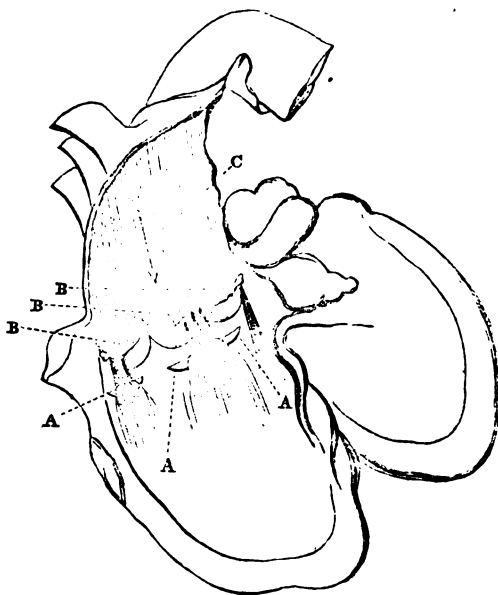
Let us turn now to the positive facts, which are fortunately so accurately detailed in your report.

1st. A sound (the musical murmur referred to) was "most intensely loud at the base of the heart."

2ndly. (I attach great value to this observation.) "It was a single regurgitant sound."

These two observations satisfactorily prove that the physical cause of the sound, viz., the vibrations on which it depended, were produced somewhere within the heart, and that the sound occurring during the regurgitation into the ventricle, the vibrations took place during the flow of blood downward, into the ventricle. Now, let us revert to the *post mortem* examination, and we find three membranous tongues, resembling smaller semilunar valves, projected into the cavity of the ventricle, about half-an-inch beneath the mouth of the aorta, just in the situation in which they would be most exposed to be thrown into vibrations by the regurgitant stream of blood, and this vibration would, I think, be much increased by the action on them of the regurgitant streams of blood, rushing into the left ventricle, through the cribriform apertures of the

valves, as seen in the annexed admirable representation of your case.



A, The membranous tongues, placed a little beneath the semilunar valves. B, The semilunar valves, thrown out into action by the pressure of the regurgitant column of blood. C, The regurgitant column of blood, returning in part into the ventricle. The streams of blood passing down through the cribriform apertures of the valves would throw the membranous tongues beneath them into vibrations, just as the air passing through the openings of a harmonicon, has a similar effect upon the tongues exposed to its action, and the result in both cases is, a "musical murmur." It may seem at first view strange, that the vibration of one or more membranous tongues in the ventricle could give rise to so loud a sound, but the practical stethoscopist is well aware what apparently disproportionately loud sounds may be produced by what appear to be even very slight and weak vibrations, and we all know what loud sounds are produced in the little child's toy by the slightest vibration of a very small portion of animal membrane, not thicker nor larger than a semilunar valve, stretched across the opening of a reed. A musical note, once produced close to the mouth of the aorta, would be readily conveyed, by the good conducting power of the contained fluid, along the arterial tree. It may probably be asked here, why was not the sound heard during the systole, as well as during the diastole of the ventricle? In other words, why was it a "regurgitant sound," as so accurately observed by you? The explanation appears to me to be easy. In the action of systole of the ventricle, the projecting tongues were necessarily thrown back, flat, against the inner surface of the ventricle, and could not vibrate; but the moment the systolic action was over, they fell out from the sides of the ventricle, and became

at once projecting membranous tongues, exposed to the action of the regurgitant blood, through the cribriform apertures of the valves, and thrown into vibrations by it; and the consequence of this was, necessarily, the regurgitant sound.

I remember a case I had under my observation in the Whitworth Hospital, and I think (although I cannot be certain) that I exhibited the preparation at one of our Pathological meetings, in which there was, during life, a very clear musical note over the sternum, although not audible, as in your case, at a distance from the chest. On the *post mortem* examination we found a tongue of bone, more than a quarter of an inch in length, projecting into the ascending aorta, which must have been kept in a state of constant vibration by the current of blood. If you now add to these, your own former case, in which a musical murmur was transmitted along the arteries, and in which "an atheromatous prolongation, more than an inch in length, stretched up into the aorta, and must have vibrated like the tongue of a Jew's harp," I cannot but think that you ought to admit that your original diagnosis was correct; and that in this last case, as in your former, your supposition has been borne out, that the "cause of the musical note was a vibrating tongue."

Future observations, guided by your notice of the musical note in your case being regurgitant, may even enable us to fix the precise situation of the vibrating tongue.

Excuse these hurried observations, drawn forth solely by the great value I attach to your case, and your clinical observations on it; and believe me, My dear Banks, sincerely yours,

D. J. CORRIGAN.

P.S.—The conversion of a portion of the aorta into a tube of bone, would (as observed by Skoda, whom you have quoted) give rise to a musical murmur, by giving the aorta somewhat the property of a trumpet; but this is of very rare occurrence, and probably never occurs without other superadded and very extensive organic disease, while the vibratory tongue may exist with comparatively little organic change. I know one instance of musical murmur, audible at a distance from the chest, which has been present for many years, and the patient suffers almost solely from the noise.

LECTURES ON DISEASES OF THE STOMACH.

BY DR. LEES,

Physician to the Meath Hospital, Lecturer on Practice of Medicine.

HÆMATEMESIS.

CAUSES—PROGNOSIS—TREATMENT.

If Hæmatemesis be caused by the irritation of poisonous substances, it may occur immediately from sudden congestion of the vessels of the stomach, or not till after some time; and then,

either as a result of inflammatory congestion, or owing to the detachment of eschars from the mucous membrane. Dr. Carswell states, that in such cases, "isolated patches, of a dark red, deep brown, or almost black colour, having the aspect of ecchymosis, are found upon the lining of the stomach. When these are examined narrowly, they are found to consist either of blood alone, effused into the mucous and submucous tissues, or of blood and a congeries of tortuous vessels. In such situations, portions of the mucous membrane are observed in a state of sphacelus." Hæmatemesis from congestion may also occur in the early stage of cancer of the stomach, when the submucous cellular tissue is passing into the state of scirrhus, and an increased quantity of blood consequently drawn to the part, to support the growth of the new tissues, before ulceration has taken place. That caused by ulceration, whether simple, chronic, follicular, or cancerous, I have already spoken of in the previous lectures on these subjects.

Hæmatemesis may also be caused by disease in some distant organ, capable of influencing the circulation in the vessels of the stomach (which itself is free from disease). This form of hæmorrhage has been termed sympathetic, and depends on a state of passive congestion, owing to venous obstruction, from some mechanical obstacle to the return of blood. The liver and spleen are the viscera in which the obstruction is most frequently seated, and next in order, the heart, lungs, and uterus. When the liver is the seat of obstruction, we generally find it smaller than natural, and in a state of cirrhosis; but when the obstruction is seated in the spleen, that viscus is mostly enlarged; but not so much from actual disease of its texture, as from distention, by an increased quantity of blood; in fact, whenever the portal system is obstructed or congested, the spleen soon becomes enlarged, as, from its highly vascular and distensible structure, it acts as a reservoir for the venous blood, and thus prevents or diminishes congestion of other organs in the abdomen, but if it is too much congested, or if induration of its substance has resulted from frequent attacks of congestion, the portal vein must relieve itself through some other channel, and hæmatemesis generally results. Latour, in his work on hæmorrhage, has recorded many examples of the combination of great enlargement of the spleen with hæmatemesis, particularly in persons who had lived in malarious districts, and suffered from intermittent fever. Mr. Twining says, that great tumefaction of the spleen is frequently seen in Calcutta, and that this enlargement often takes place rapidly, so that in a few days it can be not only felt, but seen extending far below the cartilages of the left false ribs, and in some cases filling up half the abdomen. Profuse hæmatemesis sometimes occurs in these cases, and may suddenly cause death; but in other cases, the distended spleen is relieved by the discharge of blood, "which probably comes from ves-

sels communicating directly with the splenic vein, as the enlarged viscus is often completely reduced after these discharges of blood."* In the DUBLIN HOSPITAL GAZETTE for April 1st, 1855, Dr. M'Dowell has recorded the case of a man, who was attacked suddenly with violent and profuse hæmatemesis, while suffering from abscess in the liver; and in vol. ix. of the Transactions of the Pathological Society of London, a case is reported by Dr. Hillier, in which hæmatemesis occurred from an hydatid cyst in the liver, which had communicated by ulceration with a branch of the hepatic artery, the blood having passed into the intestine along the hepatic and common bile duct.

Hæmorrhage from the stomach may be also symptomatic of some diseased condition of the blood, which is exhaled from the surface of the mucous membrane, in some cases owing to a state of active congestion, as arises in diseases characterised by profuse morbid secretions from the stomach, such as yellow fever, and also occasionally cholera, when the stomach is greatly congested, (as is well shown in a plate of Cruveilhier's,) and the fluid emitted is of a brown or dark colour, owing to the presence of small dark coagula of blood. It may also be the result of a passive congestion; and is met with in those blood diseases in which the fibrin is deficient, though the red corpuscles are in fair quantity, as we find in yellow and petechial fevers, in hæmorrhagic small-pox, and in the pyrexial exanthemata when they assume a malignant type, particularly in scarlatina: I have seen a boy die from vomiting of blood in this disease; and in another case of a child, who died suddenly in scarlatina, and whose body I examined, with Dr. William Moore, we found the stomach and intestines distended with blood, though there was not the slightest breach of surface visible. Hæmorrhage from the stomach may also happen in an opposite condition of the blood, when there is an excess of fibrin and a deficiency of red corpuscles, as in scurvy and acute purpura. Dr. Williams states, that "it appears probable, that an alteration in the *quality* of the red corpuscles and fibrin is at the bottom of the evil in these diseases." He also states, that "in several cases of Bright's disease of the kidney, he has observed the blood discs to be jagged or crenate at their margins, and otherwise imperfect; and that a total destruction of the blood discs was observed in the blood of a person who died of malignant scarlet fever with purpura; and a similar condition in acute purpura, connected with jaundice; and in cases of disturbed function of the liver, without jaundice."

Dr. Budd considers that "arrest of secretion in the liver" is a cause of hæmatemesis, as, owing to the destruction of the hepatic cells, the blood does not circulate freely through the liver, and congestion of the stomach and intestines results, "just

* Twining

as when a palpable mechanical bar is offered to the free return of the venous blood." We meet with this condition in those cases of acute yellow atrophy of the liver in which jaundice rapidly supervenes, followed by coma and convulsions, from suppressed secretion of bile; and also "in cases of jaundice, from permanent closure of the common gall-duct, when the secreting cells of the liver are destroyed."—Our prognosis in hæmatemesis ought to be always cautious, as it is in most cases a very serious symptom, the most favourable cases are those in which it is vicarious of the menstrual discharge; but even in these cases it causes much anxiety, from its tendency to recur, and from the derangement it causes in the digestive functions; but if there are other indications of organic disease, if it has a tendency to assume a chronic form, and if there be a feverish state of system induced, it is a serious case, and doubtful as to its result. The treatment of hæmatemesis must depend on its nature and cause, and may be divided into the curative and prophylactic. If the hæmorrhage be of an active or inflammatory form, strict antiphlogistic treatment should be enforced: bleed from the arm, or apply leeches to the epigastrium or anus; enjoin rest in the horizontal position; give cold drinks (iced, if possible)—lemonade, almond emulsion with nitre, water acidulated with mineral or vegetable acids. Keep the bowels open by enemata; and if the bleeding persist, apply ice to the epigastrium, and give the mixture of acetate of lead with morphia. Digitalis and hydrocyanic acid may be necessary to control the circulation; and French writers recommend the application of ligatures round the extremities. If the hæmorrhage be of the passive kind, or occurs in reduced or debilitated subjects, or depends on an altered state of the blood, we must then have recourse to the class of medicines termed styptics—as alum, acetate of lead, nitric and sulphuric acids. "Most of these remedies are astringents, and act by causing contraction of the tonic fibres of vessels and other parts; but some of them also render the blood more plastic and coagulable, and then exercise a twofold influence over the mischief."* Oil of turpentine, in doses of 20 to 60 drops, is a valuable astringent; so is creasote, when applied directly to the part. Gallic acid is a powerful astringent, when taken into the system and mixed with the blood; for though it does not coagulate albumen by itself, yet M. Pelletier has shown that it will do so if mixed with a solution of gum; "but gum is chemically identical (or nearly so) with grape sugar, which is always present in the blood; and thus the gallic acid becomes tannic acid in the blood, and is rendered chemically coagulant or astringent.†" If the hæmatemesis be vicarious of menstruation, bloodletting (if used at all) ought to be done with great caution; and the same rule should be made as to purgative medicine, which

should be only used to procure healthy and regular evacuations, and prevent the accumulation of feces in the large intestines, which females are so subject to. Ergot of rye, in these cases, given in doses of 10 to 20 grains every three hours, may be useful, but the great indication should be, to establish or restore the catamenial function; and we should therefore examine particularly into the state of the general system, as well as that of the uterine, and direct our remedies accordingly. After the subsidence of the hæmorrhage, we must endeavour to prevent its return, by removing the exciting or predisposing causes: the diet must be carefully attended to; the state of the bowels regulated; freedom from care and anxiety insisted on; and a course of chalybeate medicine given, and continued for a long time, so as to restore tone to the system, and act on the mucous membrane of the stomach.

OVARIAN TUMOR.

By ROBERT MAYNE, M.B.,

Lecturer on Practice of Physic, in the Carmichael School of Medicine, and Physician to the Hospital of the South Dublin Union Workhouse.

Ovariectomy has of late years attracted a large share of the attention of the medical profession, a number of eminent practitioners having strongly advocated this operation, whilst, perhaps, a still larger number have, with equal zeal, denounced it. Its advocates have, perhaps, made too light of the dangers which necessarily attend it, and have probably omitted to publish all their unsuccessful cases; but, on the other hand, those who decry the operation, and inveigh against its performance *under any circumstances*, may very fairly be reminded, that a large number of ovarian diseases tend to a fatal termination *when left to themselves*, and that some of them produce this result suddenly and most unexpectedly.

The propriety of undertaking this formidable operation being still, as it appears to me, an open question, it becomes the duty of those who meet with cases in point, to communicate them faithfully to their professional brethren.

The subject of the following case was aged 54. She had been married for many years, and had never had a child. Her health had been excellent until her thirty-fifth year, when she accidentally discovered a tumor deep in her abdomen, exactly in the situation of the right ovary.

When first discovered, this tumor was about as large as a good sized orange, and very moveable; its surface was smooth, and remarkably hard to the feel; it possessed very little sensibility, bearing considerable pressure from the hand without the slightest pain: and when left to itself producing little if any inconvenience.

Many years passed over, and still the tumor (somewhat enlarged, it is true, in its dimensions)

* Williams. † Ibid.

occupied its old position, but without creating much inconvenience. Occasionally it produced some irritation of the bladder, causing, for days together, slight dysuria, and sometimes a frequent desire to micturate. Sometimes it seemed to obstruct the bowels a little, producing flatulency, and colicky pain with constipation, symptoms which used to yield readily, however, to mild purgatives. Sometimes there was a sensation of weight and bearing down pain about the uterus, but without any prolapsus. These symptoms, slight though they were, constituted the sum-total of the mischief produced by this tumor during a period of nearly 20 years! That no serious suffering resulted from the presence of the tumour may be inferred from the fact, that this woman had been aware of its existence for such a lengthened period of time, and yet that she had never consulted any medical man about it. For many months she had been an inmate of the South Dublin Union Workhouse without applying for medical advice, or even intimating that she was an invalid.

In the month of January, 1856, this woman was seized, rather suddenly, with pain and soreness in the region of the tumor, which compelled her to apply for assistance. She lay on her back, with her thighs flexed upon her pelvis, and the abdominal muscles relaxed, obviously for the purpose of relieving the tumor from pressure. It was now tender, and sensitive to the slightest touch; but as yet there was no general peritonitis, because at every other part of the abdomen firm pressure was borne without complaint. There was some slight fever present, shown by an accelerated circulation and a loaded tongue, but as there was no vomiting, no very intense heat of skin, and no marked obstruction of the bowels, the inflammation was considered to be strictly limited to the tumor.

A number of leeches were applied to the right iliac region, as nearly as might be, over the tumor, to be followed by fomentations and a linseed poultice, and some mild laxative medicine was prescribed.

On the second and third days the symptoms remained nearly stationary, still there was tenderness on pressure, confined accurately to the site of the tumor, and still there was slight fever, sufficient to warrant the application of more leeches, and the adoption of a mild mercurial plan of treatment, but not sufficient to justify any alarm as to the result.

On the fourth day a new class of symptoms suddenly supervened. She was seized, all at once, with the most intense pain in the region of the tumor, followed by great anxiety of countenance, incessant vomiting, exquisite tenderness over all parts of the abdomen, a tympanitic belly, a small and rapid pulse, and a sunk look. It was now evident that peritonitis, of the very worst type, had supervened, and to combat this inflammation the utmost exertions were made by Mr. Shannon, under whose care this woman was placed, and by whose kind

permission the tumor was subsequently exhibited to the Pathological Society. Mercury was pushed to the greatest possible extent, both by inunction and by the mouth; blisters were applied extensively, and all without avail. After very intense sufferings, prolonged over about two days, her constitutional powers began to fail, and she died on the sixth day of her illness, and the third of the peritoneal inflammation.

The *post mortem* examination disclosed the following appearances:—There was intense vascularity of the serous membrane of the abdomen, particularly of its parietal layer. Large flakes of lymph, of a greenish yellow colour, coated the free surface of the peritoneum extensively, and formed numerous bands of adhesion, besides, between the adjacent viscera. The great omentum was thickened and vascular, and covered extensively with lymph. The tumor (the starting point of all the mischief) was found at the brim of the pelvis, on the right side, nearly enveloped in the convolutions of the small intestine. It was about the size of a cricket ball, oval in shape, firm and weighty to the feel, and smooth upon the surface, being covered by the folds of the broad ligament of the uterus. The uterus itself, and the left ovary, were healthy.

Removed from the body, this tumor was found to be singularly hard and resisting; all attempts to divide it with a knife proved utterly fruitless; but at length, partly by sawing, and partly by tearing, a section of the tumor was effected. It consisted, externally, of a shell of calcareous material, closely resembling bone. Internally, it contained a variety of heterogeneous materials. Some were of a cheesy consistence, and closely resembled scrofulous matter; others were not unlike softened glue; here and there, spiculae of bone were recognised by the finger; but neither teeth nor hair were discovered.

At several points of this tumor the calcareous shell was deficient; and at one of these points, in an evil hour, inflammation was lighted up, an abscess formed, the matter discharged itself into the peritoneal cavity, by a ragged orifice, large enough to admit the point of one's finger, some of the contents of the tumor escaped by the same aperture, and fatal peritonitis was the result.

If ever there was an ovarian tumour which would have justified a favourable prognosis, it was this one. For nearly twenty years it remained harmless, producing, at most, only trifling inconvenience, from occasional pressure upon the bladder, or upon the uterus, or upon the bowels; and even this trifling inconvenience ceasing when an accidental change of position, as we may suppose, released the suffering organ from pressure. Its very growth was so slow, that no reasonable apprehensions need have been entertained of serious mischief arising to neighbouring organs from an increase in its bulk. Under such circumstances, rash would have been the surgeon who dared to lay open the peritoneal cavity, to rid the patient of such an

unoffending growth. And yet, in the end, this tumor proved fatal, upon short notice, and with the most uncontrollable symptoms.

On the other hand, if ever an ovarian tumor offered facilities for removal by operation, it was this one. Its size was very moderate; it had contracted no adhesions whatever with the parts around it; and its very pedicle was so thin, that the chances of hæmorrhage would have been trifling.

I am not prepared to say what the origin of this tumor may have been. One gentleman who inspected it at the Pathological Society, conjectured that it might originally have been an extra uterine foetation. Certain it is, that there was nothing in the tumor bearing the most remote resemblance to any part of the fetal body.

CASE OF JAUNDICE, PRECEDED BY SYMPTOMS OF CEREBRAL POISONING,

AND ACCOMPANIED BY PARTIAL SUPPRESSION OF URINE.

By DR. O'DONOVAN, Belturbet.

Mrs. W., æt. 23, aborted in her third pregnancy about six months previous to her present illness; she was at the time unattended by any medical man, and suffered very much from the hæmorrhage, which was very profuse.

In the month of November, 1855, I attended her in jaundice accompanied with congestion of the liver; the treatment consisted of mercurial purgatives with diuretics. She recovered well. After some time she was attacked with acute rheumatism, but did not come under my care for two or three weeks. When I first visited her, the pains were confined principally to the plantar fasciæ, and to the backs of both legs. She was extremely debilitated; her pulse quick and feeble. She was emaciated, and complained of loss of rest, loss of appetite, and I also found that she was pregnant. I ordered her quinine three times in the day, porter, and light nourishing diet, an opiate at night, and an opiate embrocation to be applied to the legs and feet. She improved steadily, though occasionally distressed with "morning vomitings," which however yielded to the Solution of Magnesia with Tincture of Columba. For a few days previous to the 1st of February I had not seen her; in fact, she was convalescent. About this time she laboured under considerable depression of spirits, from family affairs; but I hoped, as her strength improved, she would be enabled to overcome their depressing influence.

On visiting her this day, February 1st, I was alarmed to find her in an exceedingly exhausted state; her countenance sunken and anxious; pulse 120, very weak and compressible; inclination to sleep, listlessness, answering questions slowly and at long intervals; pupils slightly dilated, sluggish, tongue red at the edges and slightly furred; bowels moved gently in the morning, and she had also voided

urine, but in very small quantity. Unable to discover any tenderness in the epigastric, hypochondriac, or iliac regions, or over the cervical vertebræ, I considered her state as depending on uterine sympathy, and ordered a mustard poultice over the heart; chicken jelly, and a tablespoonful of brandy to be given every third hour.

February 2nd.—Saw Mrs. W., in consultation with Dr. Halpin, of Cavan. The stupor and listlessness have increased; the pulse is small, 120. She can with great difficulty be induced to answer questions; when spoken to, she opens her eyes, looks vacantly, and speaks slowly, as it were dropping the words from her mouth. The bowels have not been moved, nor has she micturated for the last 24 hours. The conjunctivæ are slightly tinged yellow; there is no pain in the epigastric or hypochondriac regions.

Habeat Olei Ricini, ʒvj.

Spt: Etheris Nitr:

Spt: Terebinth: aa. ʒi.

Aq: Ment: P: ʒiv.

A mustard cataplasm to the stomach.

In the afternoon, the bowels not having acted, she got a bolus of calomel and compound powder of jalap, and afterwards an enema, which induced two dark, nearly black, motions; there has been no action of the kidneys; the stupor and debility rather increased.

February 3rd.—No action of the bowels or kidneys during the night. Other symptoms same as last report. Bolus and enema to be repeated; blister over the liver; parsley tea as a drink; brandy and jelly to be continued. In the evening she had two dark and scanty motions, like the meconium of infants, streaked with green and blue; voided about two ounces of muddy urine.

February 4th.—Is in much the same state. No evacuation of fæces or urine during the night; but stupor not so great; answers questions more readily; the entire surface of her body is jaundiced; tongue getting dry, pulse 125, breath extremely foul, but no odour of mercury. *Repetatur bolus et enema.* This evening the bowels were moved four times; discharges present the same character; voided a very small quantity of urine.

February 6th.—Spent a bad night. Severe nausea and vomiting commenced towards morning and still continue; is much distressed, restless, and impatient; pulse 130, jerking and compressible. The irritability of the stomach was checked by Solution of Magnesia and Tincture of Hyoscyamus, which also induced a little sleep; after which she became more tranquil, and the bowels were freely moved—the discharges were less dark. She passed nearly two pints of muddy urine, the stupor became less, and she answered questions more readily; her pulse fell to 115, became less jerking; and altogether she appeared improved. The bolus and enema were repeated, and she was ordered a diuretic mixture. In the evening she was much improved, and had three copious motions, of a brown colour, and voided a considerable quantity of less turbid

urine; was less dejected; her pulse 120, more full and steady; she sat up in bed and conversed cheerfully. Brandy and jelly to be continued.

February 8th.—Was called at five o'clock, a.m., and found her sadly changed, diarrhoea having set in about two o'clock; from which period to my visit she had nearly 20 dark scanty motions, but voided no urine; pulse faltering and weak—impossible to count it accurately; tongue pale, flabby, slight mercurial fœtor. Was ordered 30 minims of tincture of opium, and brandy in increased quantity. This checked the diarrhoea. She has voided no urine whatever since yesterday at mid-day.

Two o'clock, p.m.—Was urgently requested to visit her, coma having set in. She now lies on her back in a state of stupor; breathing stertorous; cold, clammy perspiration over face, hands, and lower extremities; pulse so weak and rapid as not to be counted. Mustard poultices were applied over the region of the heart, and to the extremities, and brandy was repeatedly given. At three o'clock, p.m., she appeared dying, but revived from the free use of external stimulants; and at 10 o'clock, p.m., her consciousness was quite restored, and she had improved very much; her pulse had rallied; but it is at the same time evident that the reaction is owing to stimulants alone, and that her system has got such a shock that it is impossible she can survive. She has insisted on being removed to another apartment.

February 9th.—Passed the early part of the night quietly, conversing occasionally with her friends, and occasionally sleeping tranquilly. The discoloration of her skin is more intense; at midnight the stupor returned, and it is evident nothing further can be done for her. She has passed no urine since two o'clock, p.m., on the 7th; the bowels were moved once during the night, but she was unconscious of the act. She died at midnight, without convulsion or struggle.

I am aware that the supervention of coma in jaundice has been noticed by many authors—by Drs. Corrigan, Stokes, Dunglison, and other writers; and by all as an alarming if not positively fatal symptom: but, so far as I can perceive, in their experience the jaundice would appear to have existed for some time previous to the setting in of the cerebral symptoms. The present instance, which has just fallen under my care, appears remarkable for the primary invasion of the “stupor and inclination to sleep,” while the jaundiced appearance was secondary, and slowly developed. Another feature in the case, not less remarkable, is the intermission of those dangerous symptoms, frequently relieved, but to return with greater violence, and ultimately ending fatally. At my first visit (February 1st), the discoloration of the conjunctivæ was scarcely perceptible, while the symptoms of approaching coma were formidable indeed. Not until the 4th did the yellow colour become general over the entire surface, while, on that day,

the cerebral attack was less severe, and continued to decrease until the 8th, when it again appeared with the greatest intensity.

Only one symptom (and that, so far as I can observe, unnoticed by writers on the subject), *total suppression of urine*, attended the invasion of the cerebral symptoms, and continued in an almost direct ratio to their severity; but whether as a cause of the stupor, the urea not being eliminated from the blood, thus acting on the cerebral system as a poison, or as arising from the general want of nervous energy, and to be considered as a simple lesion of the function of secretion, as often witnessed in typhus, is hard to determine; but I am disposed to look on it as having its origin in the former cause, and consequently more alarming, as less under the influence of treatment.

TREATMENT OF CHOREA, OR ST. VITUS'S DANCE.

By THOS. L. MONAHAN,

Physician to the Dublin North Union Hospital.

In the *Hospital Gazette* of December 1st, 1855, I published a case of the above disease treated and cured by the application of splints, &c. On the 19th of December, 1856, I was requested to see Master S., æt. 13, who for the last two or three days was suffering from involuntary and tremulous motions of almost all the voluntary muscles. The parents being greatly alarmed, a consultation was agreed upon. With considerable difficulty the boy was taken to Dr. Stokes. He and I arranged that the usual anti-choreic medicines should be tried; in addition, the patient had the benefit of country air and tepid shower-baths. The remedies recommended were regularly administered for over three weeks, by an experienced nurse, without any amelioration of symptoms. I then had recourse to splints: the night they were applied the boy slept well; and on their removal in the morning, there was scarcely any involuntary motion of the muscles observed. By using the splints for a few days and nights, the boy was restored to convalescence. The relief obtained by their use was so sudden and striking, that neither the parents or patient could be induced altogether to dispense with them, lest the disease should return. The above are the only cases of chorea in which I have used splints; they proving efficacious, after the failure of the usual remedies, induced me to report this case.

SURGICAL SOCIETY OF IRELAND.

A meeting of the Surgical Society was held on Saturday evening, February 7,

Dr. JACOB in the Chair.

Dr. BENSON exhibited a specimen of *Malignant Disease of the Omentum*. The subject of the dis-

case was a gentleman about 50 years of age, of remarkably healthy appearance, resident in the country. He considered himself to be in perfect health until about four months ago, when he began to suffer from what may be termed severe dyspeptic symptoms, and shortly after he discovered a tumor in the abdomen. His medical attendants in the country were not agreed as to the nature of this tumor. One considered it to be in the parietes of the abdomen, and another referred its situation to the abdominal cavity. The gentleman removed to town toward the end of December, and placed himself under Dr. Benson's care. The prominent symptom then, and for the remainder of his life, was obstinate vomiting. There was no pain in the tumor. Dr. Benson said that he, on several occasions, availed himself of the assistance of an eminent surgeon, and also of a distinguished physician of the metropolis; and that although towards the close there was no doubt but that the disease was malignant, during the progress of it, there was great difficulty in coming to any decided conclusion as to its nature or situation: the natural difficulties were increased by the constant distension of the abdomen—the fatty condition of its parietes—the very small quantity of serum which, even after death, was found in the peritoneum—and, lastly, the situation of the tumor, which occupied the hypogastric region, instead of being curled or folded up on itself, as omental tumors are generally found. The alvine discharges were reported as having been small, hard, flattened, and very scanty; which, in a measure, confirmed the diagnosis of the tumor being intra-abdominal. There was no interruption, however, to the passage of a tube up the rectum; nor, on inspection, were the feces so characteristic as they had been described. On *post mortem* examination, however, it was found that a hard scirrhous tubercle of considerable size occupied the meso-cœcum and meso-rectum, which would fully account for those symptoms. Although the surface of the liver seemed free from them, some scirrhous tubercles were found in its substance.

Medicinal use of Mora Excelsa and Eryngium Fatidum.

Dr. HARGRAVE brought under the notice of the Society the effects of some medicinal agents, with which he had been supplied by Mr. Moore, the curator of the Royal Dublin Society's garden. He first alluded to the *Mora Excelsa*, a decoction of which—

Formula { Corticis Mora Excelsæ, ʒij.
Aquæ fontanæ, ʒviiij.
Decoque ad ʒvj.—

he had found of the greatest service in the cleansing and healing of foetid ulcers. The bark of the *Mora Excelsa* had been brought from Guiana, and presented to the Gardens of the Royal Dublin Society by Mr. Mac.

Dr. Hargrave next alluded to the *Eryngium*

Fatidum, or *Furweed*, from the West Indies, which had been much praised for its utility in cases of hysteria and similar affections. Dr. Hargrave had tried it in a very severe case of prolonged singultus, which had resisted the ordinary modes of treatment, and it proved perfectly successful.

Formula { Eryngii Fæt: ʒij.
Aquæ puræ, ʒviiij.
Decoque ad ʒvj.
Capiat ʒi. ter in die.

Partial Amputation of the Foot.

Mr. TURNELL detailed the particulars of a case in which he had, three years ago, removed the *Cuboid, external cuneiform, proximal ends of the fourth and fifth Metatarsal Bones, and anterior portion of the Os Calcis*, for scrofulous disease of the tarsus. Sinuses existed at the time of the operation to such an extent, that a probe passed with ease through and through the tarsal range. The child's parents had both died of phthisis, and the strumous diathesis was well marked in the little patient herself.

Recovery, however, had been complete, for the child appeared before the Society, with but little deformity of the foot itself, and the power of progression perfect. The flexion and extension of the ankle-joint had not been interfered with by the operation.

Syphilis in the Fœtus.

Dr. MACSWINEY detailed, at considerable length, the history of some cases met with by him in obstetric practice, where a *venereal taint* existing in the male parent, contaminated both the product of conception and the female parent. The presence of the syphilitic virus, exercising its deleterious influence, was well denoted by what occurred at several pregnancies undergone by these females, previously to coming under Dr. Mac Swiney's care; for either the ovum had been prematurely expelled, or the children were still-born, (having died some days before birth,) and had the skin peeled in large patches off their bodies, or they were born prematurely in the most enfeebled state of vitality, scarcely breathing, and unable to suckle, and covered sometimes with a livid papular eruption over the entire body. The mother, in one case, had suffered greatly from syphilitic sore throat through the entire course of two pregnancies. Both parents, in those instances, were remarkably *healthy-looking*, and the mothers had met with no accidents which might account for the destruction of the impregnated ova.

Dr. MacSwiney argued that the infection was first conveyed from the male parent to the fructified ovum, and then from the fœtus in utero to the mother; and he maintained that the plan of treatment adopted by him, and originally advised by the late Dr. Beatty of this city, namely, the administration of mercury to both parents, was the

only proper and effectual one for cases of this description.

Dr. MacSwiney said that this mode of treatment, in the cases which he reported to the Society, was followed by the most entire success, complete cure of the "Lucæ," and subsequently, the birth of *healthy children* at the *full term* of gestation; those children, now some months old, being at the present time alive and well.

PATHOLOGICAL SOCIETY OF DUBLIN.

A meeting of the Pathological Society was held on Saturday, January 17th.

Dr. LAW, V.P., in the Chair.

Fungus of the Antrum.

Professor R. W. SMITH exhibited a cast of Malignant Disease of the Antrum, which occurred in a man about 60 years of age; and gave the following account of the case. The patient who was the subject of the disease represented in this cast, consulted me respecting a small tumour, about the size of a nut, situated immediately above the alveolar border of the left superior maxillary bone. It had been growing for a few months, was free from pain, and presented at this period no mark of malignant disease. The mucous membrane was moveable over it; it was very firm to the touch, but gave the feeling of elasticity. I proposed to make an exploratory puncture into it, to ascertain the nature of its contents; but the man refused to permit its being done, and I lost sight of him for three or four months. At the expiration of this period he again called upon me for advice. He had been, in the interval, under the care of another surgeon, who recommended the excision of the superior maxillary bone. The tumor had attained a considerable size, and its malignant nature was too evident. The face was greatly deformed; the cheek bulged out; the integuments adhered to the tumor, which had filled the left nostril and the cavity of the antrum; the nose was pushed to the right side; the palate depressed; the palate process of the superior maxillary bone broken, changed into a fleshy structure, and perforated by a large aperture, from which was discharged a most offensive matter, and which gave exit, from time to time, to alarming gushes of blood. The tumor had become nodulated, and the skin had ulcerated at its upper part; the left eye was closed. The profuse purulent discharge, the frequent losses of blood, the pain, &c., were producing their usual effects upon the system: the man had become pale, sallow, and emaciated, but though without hope, was calm and resigned. From this time until his death, a period of two months, the scene was one of unvaried and unmitigated suffering. The tumor did not increase, but large portions of it were destroyed by ulceration and sloughing. The teeth on the left side all became loose. The

ulceration destroyed the lower, and the greater part of the upper eyelid, and the left side of the nose; the globe of the eye inflamed, soon utterly perished, and, with the muscles and other contents of the orbit, formed one homogeneous and disorganized mass. The growth and pressure of the tumor, and the process of ulceration and sloughing, at length threw into one the cavities of the antrum, the nose, the mouth, and the orbit; and during each expiration, the air, forcing its way through purulent matter and sloughing tissues, bubbled out through the lower part of the orbit. Towards the close of life, rending pains of the head occurred; signs of inflammation of the membranes of the brain set in, and coma, which was the immediate precursor of death.

Tuberculosis and Wound of the Lung.

Dr. BANKS exhibited the lungs, and briefly reported the history of the case.

A young man, æt. 27, but looking much younger, was admitted into the Whitworth Hospital on the 16th of December. He had been a needle-grinder, but on the declaration of war with Russia, he abandoned his trade and entered the army. He states that his health had been good, and that his family, as far as he knows, had been healthy; but his frame must have always been a feeble one.

He was a private soldier in the 23rd Regiment, and on the 20th of September, 1854, as the regiment crowned the heights of the Alma, he received a gun-shot wound. He lay on the field for some hours, bleeding from the mouth and from the wound. Before he received aid the hæmorrhage had ceased from the latter. It was found that a bullet had entered about an inch and a-half below the left clavicle, and passed out at about the same level posteriorly. The bullet had passed through the apex of the lung.

He was removed to the hospital at Scutari, where he came under the care of Dr. M'Munn, of the Royal Artillery. During his sojourn in the hospital, small fragments of bone came out of the posterior aperture of the wound. After remaining nine months at Scutari, he embarked for England; during the voyage he had distressing cough and difficulty of breathing, the expectoration being also exceedingly abundant. On his arrival in England he was sent to the Chelsea Hospital. From this, after some time, he was removed to Chatham, when he was finally discharged from the service, twelve months before his admission into the Whitworth Hospital.

After his discharge, he remained for a few months with his family at Sheffield; but being recommended by a physician to try his native air, he came to Ireland.

After his arrival in Ireland, he experienced a slight improvement in his health. On first coming under Dr. Banks's notice, he presented the appearance of a person in the advanced stage of tuberculosis of the lungs. A physical examination deter-

mined the existence of a cavity of large dimensions in the left lung. The signs resembled closely those of pneumo-thorax with effusion. The metallic phenomena were present, and there was, moreover, audible a splashing sound on succussion. These sounds, however, were limited in extent, and there was no tympanic resonance.

He lingered until the 13th of January, 1857, having for some days before his death had profuse hæmoptysis. The body was extremely emaciated, and presented a cicatrix beneath the left clavicle, and also one posteriorly. The necrotomy revealed the presence of a vast tubercular cavity. The apex of the left lung was adherent to the costal pleura, so that it was impossible to remove the lung without tearing it. The investing false membrane was of unusual thickness; the cavity was traversed by many bands, and the walls were smooth. At the upper and posterior part of the wall of the cavity there was a circular aperture with well-defined edges.

Dr. Banks observed, that in this case life was prolonged about two years and five months from the receipt of the wound. He regretted that his friend, Dr. M'Munn, had lately left Ireland, on foreign service, as he could have otherwise received an accurate history of the case. There could be no doubt of the fact of the ball having traversed the apex of the lung. From the delicate constitution of the man, and from the nature of his occupation, it is not improbable that, at the time he was wounded, the apex of the lung was the seat of tubercular deposition, and that the existence of adhesion, through the intervention of a cap of false membrane, may have been instrumental in saving his life. With respect to the remarkable metallic phenomena, in this instance, it may be observed, that there was a striking analogy to a case some time since brought before the Society, in which a vast cavity was traversed by bands like carneæ columnæ, which, probably acting as vibrating chords, gave rise to the phenomena mentioned.

ABSTRACT OF THE PROCEEDINGS OF THE BELFAST CLINICAL AND PA- THOLOGICAL SOCIETY.

SESSION 1856-7.

Tenth Meeting, Saturday, January 3rd.

The PRESIDENT in the Chair.

Dr. HEANY read the history of the following
Case of Puerperal Convulsions, followed by Mania.

About nine o'clock, on the morning of the 3rd September last, I was called to visit Mrs. I., a young woman of 19 years of age, and in the ninth month of her pregnancy. I found her just recovering from a fit of convulsions. Upon inquiry, I learned that she had been suffering from them dur-

ing the whole of the previous night, with intervals of about half an hour between each attack; I learned also that for the preceding three days, she had suffered greatly from a very severe pain in the head and occasional vomitings, and I found that her tongue had been rather extensively injured during the fit; pulse 126. Before I had finished my inquiries, she was again seized with an epileptic fit of great severity, during her struggle, in which bloody froth issued from her mouth, and her lips and face assumed a congested and purplish appearance, she did not shriek, but there was evident spasm of the muscles of the larynx. I immediately proceeded to draw blood from her arm, not only with a curative, but also a prophylactic view; I took away about 24 oz. of blood: this appeared to produce but little effect, as she had another fit of equal severity in the course of half an hour. On examination per vaginam, I found the head of the child pretty low down, but the os uteri undilated. In a little time further she had another fit equally severe, after which I untied the arm, and drew off about 16 oz. more of blood, after which I administered a turpentine enema. Notwithstanding the prompt administration of these remedies, the fits continued to recur at irregular intervals. It was impossible to administer any medicines by the mouth, owing to her total state of unconsciousness. I apprised her friends of the dangerous condition in which she was placed, and it was determined that additional advice should be obtained. An expert accoucheur was called in; and as the os uteri had now dilated to about the size of a shilling, and its margins were thin and soft, we determined to await its more perfect dilatation, and, if possible, apply the forceps. Cold applications were applied to the head, and turpentine fomentations between the shoulders; the latter with a view to arouse her to a state of feeling, and act as a derivative from the brain and spinal cord. The convulsive motions were now accompanied with strong uterine action; and in about one hour from the arrival of my colleague, I was enabled with ease to effect delivery with the forceps. The child was still-born, and the placenta shortly followed. The convulsions, however, continued for 32 hours after, the intervals gradually getting longer, about eight hours, before they finally ceased. I was again induced to bleed her to 10 oz., there being symptoms of an increased determination of blood towards the head. When the power of swallowing was restored, 10 grains of calomel were administered, followed by a draught of castor oil and boluses of camphor, tartar-emetic, and hyosciamus. The urine was examined, but no albumen was found present. On visiting my patient on the second day after delivery, I found that her intellect was completely deranged, the derangement resembling the symptoms of "*mania a potu*," except that there were no tremblings; she fancied that she had been speaking with the dead, and she was constantly looking to various parts of the room,

where persons were supposed to be assembled, plotting mischief against her. It was with the greatest difficulty she could be persuaded to take either food or medicine. I directed the continuance of the cold applications to the head, and epithems of turpentine on flannel, wrung out of hot water, to the abdomen, as the lochia had ceased to flow. I ordered a mixture of the spiritus mindereri and spirits of nitre. These means, with the occasional use of calomel, castor oil, and turpentine enemata, were the principal means that were adopted for the course of four days, when she was again restored to her proper senses, and afterwards made a very good recovery, and at the present time is perfectly well in every respect. The chief peculiarity in this case, was the supervention of the mania on the termination of the convulsions; and the question that may arise, whether the bleeding, in all, to the extent of 50 oz., may have had any influence in producing the mania; in my opinion, it had not; and (even if it had) I think the bleeding was more than justifiable, taking into consideration the concurrent testimony of almost all the best obstetrical authors and practitioners, as to the propriety and necessity of a free and copious blood-letting in puerperal convulsions, and that there is less risk of life from this form of mania (even were it possible to foresee it,) than there would be from extreme congestion of the nervous centres, or from apoplexy, a result not uncommon in this disease.

The PRESIDENT reported, as occurring in his practice, the following

Case of Vaccinia and Rubeola running their course together, and followed by Lichen Lividus.

In a patient, five months old, the arm, on the fifth day after vaccination, showed a very minute but distinct vesicle; the child was somewhat feverish, and had been restless and fretful during the preceding night, which the nurse referred to dentition. On the seventh day the vaccine vesicle was progressing, though slowly; the fever continued, and catarrhal symptoms had set in, with a rash over the back and chest, not well defined. The children in the adjoining premises were, at the time, passing through an attack of measles. On the following day, the eighth, the measles were well out; the vaccine vesicle arrived at maturity on the tenth, and on the twelfth was surrounded by the usual erythema, or roseola vaccina of Willan. Under mild cooling treatment, the measles rash began to fade away on the third day from its appearance, and was soon entirely gone, viz., on the twelfth from vaccination. Five days after, viz., on the seventeenth, a distinct eruption of lichen lividus appeared over the face and chest, and continued to come out in successive crops for the space of eight days, attended by itching, and leaving behind minute flea-bite-like spots, which after a week disappeared. The other children in the house, three in number, were, at the same time, attacked by measles, and in

every one of them, also, the measles were followed by the lichen rash; in one of these there was much swelling of the face. The President remarked on these cases as bearing on the opinion of Devergie, who is inclined to consider lichen lividus contagious. Some discussion arose as to the opinion of Hunter, Cazenave, and others, who believe that one eruption always suspends the march of any other with which it may be complicated. In the foregoing case, the vaccinia was merely rendered more slow in its progress, not suspended. Some of the members were of opinion, that, as a general rule, the rapidity of development and maturity of the vaccine vesicle was in the inverse ratio of the age of the patient, being more rapid in the very young.

Dr. MOORE exhibited

A Hand shattered by a discharge of a pistol,

the palm being completely lacerated. Amputation was performed above the wrist, about one hour and a half after the accident. The wound healed by the first intention. Dr. M. recommended an early operation, to avoid the risk of tetanus, which is more likely to follow the laceration of such tendinous structures. He also exhibited a

Phalanx of the Great Toe, removed in consequence of the non-union of a compound fracture.

In this case, shortly after the occurrence of the accident, there were muscular twitchings along the limb, as far up as the hip, which ceased when suppuration set in.

The SECRETARY presented from Dr. HALPIN, of Cavan, a cast of the abdomen of a patient in Cavan Union Hospital, in whom there was an

Abnormal Enlargement of the Superficial Abdominal Veins.

The patient had a severe attack of dysentery in 1852, from which he recovered. As yet the cause of the enlarged and varicose veins is a matter of surmise.

Dr. HALPIN also sent for exhibition the cast of the foot of a man who had the

Astragalus removed, in consequence of Compound Dislocation.

Dr. H., in his communication says:—"I also send a cast I made, of an extremely interesting case, that occurred in the Co. Cavan Infirmary, about 24 years back, compound dislocation of the astragalus. Reduction was found impracticable, and the dislocated astragalus was extirpated. It is upwards of 20 years since I made the cast. The man is alive still. The motions of the foot are imperfect. There is no spring in the arch of the foot. It will be observed that the foot is forelengthened; the opposite doctrine is maintained by some practitioners, that the foot is foreshortened after this accident.

Eleventh Meeting, Saturday, January 10th.

The President, Dr. M'GEE, in the Chair.

Mr. BROWNE introduced a patient presenting an example of

Congenital Malformation of both Irides,

a deficiency existing in the lower margin of each. He referred the Society to Mr. Wilde's interesting paper on such malformations. Mr. B. also exhibited a

Tumor of a Scirrhus character,

removed from the breast of a female aged 62 years.

Mr. H. M. JOHNSTON presented a

Specimen of Perforating Ulcer of the Ilium.

The patient, a sailor, had been for weeks suffering from diarrhoea. On arriving in port he was admitted into hospital for a frostbitten condition of the feet. On the evening of his admission he was suddenly seized with symptoms of perforation of the intestines, and died in about 15 hours after. When the abdomen was opened gas escaped; there was a large amount of seropurulent effusion, and other evidences of intense peritonitis. The perforation was discovered in the upper third of the ilium. The ulcer occupied the site of one of the glandulae solitariae, and had a well-defined margin. There were several other ulcers, similarly placed, in the tract of the ilium. The mucous membrane in the intervening space appeared healthy. Mr. Johnston was of opinion, that during his passage he had been labouring under typhoid fever; and he regarded the ulcerated state of the glands as the pathological result of that disease.

Dr. SEATON REID exhibited the

Kidneys of a patient who had recently died of Phthisis,

in the Union Hospital, and who had been diabetic for six or seven years. She had visited the hospital on several occasions; the urine, during her stay, varied from four to five quarts daily, and had a specific gravity of from 1.034 to 1.040; and always gave indications of sugar, on the application of Heller's test. Two days before death the urine was reduced to three pints daily, but still was distinctly saccharine. Rennet, opium, iron, cod-liver oil gave but temporary relief; her death being caused at last by a profuse diarrhoea, which was probably the cause of the diminished amount of the urine. The kidneys, on removal from the body, were found intensely congested, rather smaller than usual, but the tubular structure apparently healthy. Dr. Reid having remarked that he did not present them as showing the pathological seat of diabetes, noticed briefly the entire change in our views of this disease that had been caused by the experiments of Dr. Claude Bernard, of Paris, who had proved that one of the natural functions of the liver was to secrete sugar; that this was always capable of detection in the blood,

after it had passed through the liver, and till it reached the lungs; that it was formed irrespective of the digestion of vegetable substances, being found even in the chick, before it had escaped from its shell. Dr. Reid then referred to the very interesting and almost fabulous results that followed the irritation of different parts of the fourth ventricle, in the experiments of Dr. Bernard. One point, on being irritated, caused the animal to suffer under saccharine diabetes; another point producing simple diuresis; and a third, the secretion of sugar, without any increase in the amount of urine. These results caused him to look with much interest to the examination of the brain in this patient, with a view of ascertaining whether, in the human diabetic patient, any morbid state existed in the fourth ventricle, that could be looked upon as producing this fearful disease. Anxious, therefore, for a careful examination of the brain, Dr. Murney, Demonstrator in the Queen's College, kindly consented to dissect it for him, after its removal from the body; but after a most careful and cautious examination of the region of the fourth ventricle, he found nothing to indicate that in this patient there had existed any kind or amount of disease in that part of the brain to which her attack of diabetes could be referred.

Dr. MOORE exhibited an example of

Pulpy Degeneration of the Synovial Membrane of the Knee-joint, and Ulceration of the Cartilages.

Also a *Tumor of a scirrhus character, removed from the breast.*

EAST INDIA COMPANY'S SERVICE.

QUESTIONS PUT AT THE WRITTEN EXAMINATION FOR ASSISTANT-SURGEONS, JANUARY, 1857.

ANATOMY AND PHYSIOLOGY. Monday, January 12th—10 to 1 o'clock. Examiner, Mr. BUSK.

I. Descriptive Anatomy.—1. Describe the duodenum; its structure, relations, functions, vessels, and nerves. 2. Indicate the limits of, and describe the parts exposed by dissection in the space circumscribed by the borders and attachments of the masseter muscle, including the zygomatic fossa. 3. Describe the dissection of the popliteal space. 4. Enumerate in order of superposition the parts divided in cutting down upon the first rib, above the clavicle, the incision being parallel with the clavicle. 5. The pons Varolii and medulla oblongata having been removed, describe the base of the brain, as thus exposed; tracing the remaining nerves to their true origins. **II. Minute Anatomy and Physiology.**—6. Describe the minute anatomy of the spleen, and the peculiarities of the splenic blood. 7. Describe the structure of the walls of the larger and smaller arteries, veins, lymphatics, and capillaries. 8. Enumerate the various excretions, indicating the average daily amount of each in an adult man; and indicate the sources whence

they are derived, and the channels through which they are eliminated.

SURGERY. Monday, January 12th—2 to 5 o'clock. Examiner, Mr. PAGET. 1. Describe the malpositions of the lower extremities which are usually observed in the successive stages of scrofulous inflammation of the hip-joint; explain the difference between the apparent shortening and the real shortening of the limb; and say in what other diseases any of the same malpositions may occur, and how these diseases may be distinguished from that of the hip-joint. 2. What are the chief caustics employed in the treatment of phagedænic, rodent, lupous, cancerous, and other allied forms of ulcer? Give an account of the methods of applying at least three of them. 3. Give an account of loose cartilages in the knee-joint—of their probable origin, seat and manner of formation, and effects. 4. In a large general hospital, would you, or would you not, set apart wards exclusively for the treatment of patients after operations? State both the advantages and the disadvantages of the plan that you would adopt. 5. What diseases within the skull are likely to occur in connexion with chronic suppuration or ulceration in the internal ear? How would you endeavour to prevent them; and what symptoms would make you suspect the occurrence of any of them? 6. Give an account of the disease generally called fissure or irritable ulcer of the anus; mention its chief diagnostic symptoms, and the best means of curing it. 7. Enumerate the causes of retention of urine. 8. What are the most characteristic signs of fracture of the neck of the femur; and how would you distinguish this injury from fracture of the pelvis, from dislocation of the femur on the dorsum ilii, and (when there is no shortening of the limb) from the consequences of a severe blow on the trochanter major producing neither fracture nor dislocation.

MEDICINE. Examiner, Dr. PARKES. Tuesday—2 to 5 o'clock. 1. Describe the symptoms of an apoplectic fit. What are the chief structural lesions of the brain or vessels which precede cerebral hæmorrhage? What treatment would you adopt during the fit? 2. A woman, aged 30, was ill for three years with well-marked symptoms of phthisis pulmonalis. She then became extremely depressed in spirits, irritable, and odd in manner, and occasionally lost for a time the memory of persons and things. After this had continued for two or three months, she began to complain of severe frontal headache, and was soon afterwards attacked with occasional violent vomiting. There was some intolerance of light; the pulse was quick and the skin was hot. Eight days before her death she became extremely confused, ceased to know her relatives, declined to answer questions, and gradually became comatose. For five days before her death she had retention of urine, but there were no other paralytic symptoms. Describe the appearances which would be present in the brain and lungs on *post mortem* examination. 3.

What are the symptoms of acute pericarditis?

4. A man, aged 33, suffered for six years from cough, expectoration, and occasional slight hæmoptysis. For nine months before the date of the following attack the cough had increased, and he had rapidly lost flesh. On the 16th of December he was suddenly seized with a sensation of great constriction, and then of intense pain in the left side and the left front of the chest; the breathing became very quick; the pulse frequent and feeble; the extremities cold; the skin clammy with cold sweat. The patient could only lie on the left side, though formerly the position on the right side had been easiest to him. On the following day the pain was less, but was still excited by every respiration and movement. The left side was found to be enlarged, and the heart was displaced to the right. From what causes could such an attack arise, and which cause was the probable one in this case? What physical signs must have been present? What treatment would you have adopted? 5. What are the causes of enlargement of the spleen? How would you recognise such enlargement? What microscopical conditions of blood may be coincident with it? 6. How would you distinguish between the diarrhoea of typhoid fever and that of dysentery? Mention the signs derived from the characters of the stools, as well as from the other symptoms. 7. Enumerate some of the principal diseases in which albumen may be found temporarily or permanently in the urine? 8. What are the symptoms and treatment of placenta prævia? 9. What are the chief official preparations of iron? Under what circumstances would you employ iron as a remedy? 10. If you were appointed surgeon to a crowded troop or emigrant ship, what measures would you take in order to preserve the health of those on board?

NATURAL HISTORY. Tuesday, 10 to 1 o'clock.

Examiner, Dr. HOOKER. 1. *Botany, etc.* (Answer five or more of the following questions) 1. What are the different layers of the bark of a tree, and how are they developed? 2. How are epiphytes distinguished from parasites? Give examples of both. What are the characters of the natural orders gramineæ, compositæ, and umbellifera? and give examples of each used in medicine. 4. Describe the roots of ipecacuanha, orchis, smilax, and ginger; give the names and natural orders of the plants to which they belong. 5. Give the names, natural orders, and native countries of the plants producing gamboge, hemp, tamarind, benzoin, scammony, and jalap. 6. Describe the structure of an orchideous flower. 7. What does a grain of wheat and barley consist of? 8. What is yeast, how is it developed, and what are the chemical changes it effects? 9. Mention some natural orders and genera of plants which abound most in saline and in nitrogenous soils. 10. Mention some of the most abundant products of the cells of plants, and their chemical composition. 11. What is starch chemically and microscopically; and how is

it converted into sugar? 12. Define the terms protoplasm, cytoblast, and primordial utricle. 13. What are the changes which vegetable food undergoes when assimilated by animals; and how does it supply animal heat? 14. Why is a knowledge of vegetable physiology essential to a right understanding of animal physiology? 15. What are mist, dew, and hoar-frost? 16. What are monsoons and trade-winds? II. *Zoology*. (Answer three or more of the following questions.) 1. Describe the process of fecundation in fish and in insects. 2. What are the principal races of men? how are they distinguished and distributed over the surface of the globe? 3. What animals yield oil used in commerce and medicine? and to what genera and families do they belong? 4. What is the economy of an ant-hill and of its inhabitants? 5. Define the terms species, genus, organ, function, instinct, anatomy, and physiology. 6. Describe the respiratory apparatus in birds, fish, reptiles, insects, and arachnida. 7. What are tapeworms and ascarides? how are they developed and propagated?

The following gentlemen passed the examination. The names are arranged in the order of proficiency. There were forty-six candidates.

CAYLEY, Henry, M.R.C.S., Eng.
 VANS BEST, Alexander, M.B., M.R.C.S., Eng.
 GILLET, Carthew, M.R.C.S., Eng.
 WHITE, James Henry, M.R.C.S., Dub.
 PENNY, James, M.D., Lond.
 SIMPSON, Alexander, M.A., M.D., M.R.C.S. Eng.
 HILSON, A. A., M.R.C.S., Ed.
 CARNEY, John, M.R.C.S., Ed.
 DICKINSON, James Charles, M.R.C.S., Eng.
 ROSS, James, M.B., M.R.C.S., Ed.
 SMITH, William C., M.D., M.R.C.S., Ed.
 RADDOCK, Charles Edward, M.R.C.S., Eng.
 POWELL, Thomas, M.R.C.S., Dub.
 SHIEL, John, A.B., M.B., Trin. Coll., Dub., M.R.C.S., Dub.
 KELLY, William P., M.R.C.S., Dub.
 HEARD, Samuel J., M.D., M.R.C.S., Ed.
 LALOR, James, M.R.C.S., Ed.
 SMITH, Arnold, M.D., M.R.C.S., Ed.
 DE FABECK, William, M.R.C.S., Eng.
 WHITTON, George E., M.B., Trin. Coll., Dub., M.R.C.S., Dub.
 BYRAMJEE, Rustomjee, M.D., M.R.C.S., Eng.
 BEAUMONT, Thomas, M.R.C.S., Dub.

Selections from British & Foreign Journals.

Case of Cancerous Disease of the Lungs, Left Scapula, &c. By Professor CARL SANTESSON, of Stockholm.

Anders Fredrik Andersson, aged 25 years, was admitted into the surgical division of the hospital on the 16th September, 1852. The patient, who

was in the habit of carrying heavy loads on his shoulder, and also frequently got blows on the same, observed, at the end of last May, "occasional cramps about the left scapula and shoulder." There was developed, according to his report, in a single night, a large tumor on the shoulder in question, in the region of the supra-spinous fossa. The occurrence of the tumor was accompanied by severe pain in its situation and the parts around. This pain has since continued constantly, although it varies considerably in degree at different times. Once during the summer the pain had almost entirely ceased, but about a month later—that is, about the middle of August, 1852—it began again to increase in intensity. It was felt most acutely during the night, and when the patient was at rest. At the same time that the pain in the shoulder recommenced, pain set in in the waist, on the left side. This proceeded from the back and the superior lumbar vertebrae, extending downwards and forwards. This pain in the side has tormented the patient much more than that in the shoulder, yet he has not observed any redness or swelling in the part. The tumor on the shoulder has not, according to the patient's report, increased much, but he thinks he has observed that it has shifted nearer to the spine. He says he has latterly emaciated, and that his appetite is diminished. At home he was cupped, and used a liniment, but without any beneficial result. His state on the 17th September was as follows:—the patient was emaciated; had a pale, debilitated appearance; he complained most of pain in the left side, with tenderness in the same situation, as well as of cutting pains in the left shoulder. On examining the latter, a deep-seated tumor was found, of the size of the fist, but more oblong, filling up the entire of the supra-spinous fossa on the left side, and extending towards the clavicle. Its boundaries could not be accurately defined, in consequence of the thickness of the superjacent soft parts. To the touch it felt elastic. A similar swelling had commenced in the infra-spinous fossa, which had, however, not as yet attained so considerable a size as that just now described. There was no discoloration of the skin, which was perfectly moveable over the tumor. The patient said the tumor was tender at the edges, but not in its middle part; there was also tenderness towards the spine and base of the scapula. The tenderness in the side, already mentioned, commenced at the outer boundary of the dorsal muscles, in the region of the kidney, and extended towards the left side; it was also felt on pressure over the crest of the ilium. Neither redness nor swelling of the side was discoverable on examination. The patient was treated with poultices to the swelling on the shoulder, and a blister to the side, in connexion with tonics, and mild aperients for habitual constipation, from which he suffered. Under this treatment the pain diminished, sleep and appetite began gradually to return; but in other respects the patient's state

continued much the same until the middle of October, when it was observed that the power of contracting the bladder was impaired. This by degrees increased, and at length passed into complete paralysis, so as to necessitate the constant use of the catheter. Sensation in the lower extremities slowly diminished from the beginning of this month, as did the power of motion—the loss of the latter taking place more quickly; and the patient was often distressed with involuntary twitchings and occasionally recurring painful sensations in the legs. The loss of sensibility subsequently advanced progressively upwards, and finally extended to the epigastrium. During the latter days of October paralysis of the rectum supervened, with symptoms of a similar condition of the other parts of the intestinal canal—inability to digest the food taken, obstinate constipation, and very intense and painful flatulence. In the beginning of November signs of pneumonia in the right, and of pleuro-pneumonia in the left lung, set in; there was profuse perspiration, general restlessness and pain, with severe pain over and around the left humeral region, and down the corresponding extremity. There were bedsores over the scapula, the sacrum, and the back part of the lower extremities. The debility constantly increased, and particularly during the last two days the strength sank rapidly. The patient died on the 14th of November, 1852.

Post mortem examination.—The brain and its membranes presented nothing remarkable. The lungs were loaded with carcinomatous deposits, from the size of a hazelnut to that of a walnut, which in the right lung were partially softened, and formed abscesses, some of which had discharged themselves into the pleural sac. The right costal pleura was found, particularly posteriorly, invested with a false membrane. In the same pleural cavity was found about a pint of fluid effusion, which in itself appeared to be clear, but was mixed with the contents of the abscesses in the lung, which had opened externally. The liver was large, and congested with blood, as were the kidneys, the cortical substance of which was hypertrophied. The other viscera presented nothing worthy of note. The left scapula, both anteriorly and posteriorly, and in its whole extent, was embedded in a fibro-cellular tumor of a carcinomatous nature. This tumor was of considerable size, surpassing the normal extent of the scapula in all directions; it had destroyed the very substance of the bone in the scapula, so that only at its inferior angle and at the glenoid process, where the cartilage was unchanged, did any of the skeleton remain. With these exceptions, there were found only here and there smaller laminae of bone, the remains of the original scapula. In the region of the last dorsal vertebrae there was found a smaller tumor, of the same nature as the foregoing, in a state of commencing softening, which extended on the left of the spinal column, into the very spinal canal, with-

out, however, having attacked the membranes of the medulla. The cartilage between the last dorsal and first lumbar vertebrae was completely destroyed, and its situation was occupied by a softened cancerous mass, which destructive process had likewise extended to the bodies of the neighbouring vertebrae. Corresponding to this part, there lay, in front of the membranes, on the medulla spinalis itself, and on the posterior aspect of the terminal cone, a cancerous tumor, of the size of a hazelnut, below which the remaining part of the spinal marrow was somewhat atrophied.

Hr. V. Lundberg, whom the patient had consulted shortly before his admission into the Seraaphim Hospital, added, that he seemed to be of a strong constitution, and that his habit of body, at that time, exhibited no sign of the presence of so malignant a disease, which there was so much the less reason to suspect, as the patient stated that the tumor on the shoulder had developed itself in the course of a few weeks. On closer examination, however, Hr. L. had ascertained the serious nature of his illness, and therefore sent the patient to hospital.—*Transactions of the Swedish Society of Physicians.*

Correspondence.

ISSUE-MAKING.

To the Editor of the Dublin Hospital Gazette.

SIR,—In reply to "Subscriber," (*vide* DUBLIN HOSPITAL GAZETTE, January 1st, 1857,) I am tempted to offer the following brief suggestions.

Let him cut a hole of the required size and shape in a piece of leather previously spread with adhesive plaster, and apply it to the part in which he wishes to insert the issue.

Next, let him introduce into the hole, pulverized *potassa cum calce*, in quantity sufficient to cover the skin; and let him then drop upon the powder spirits of wine sufficient to dissolve it (two or three drops will be enough); this done, let him cover the hole with another piece of the same plaster, large enough to project some distance beyond its margin, and leave it so for 24 hours.

At next visit, the entire may be removed, and he will then find a slough of the proper size, slightly depressed, of a brown colour; in short, just such a slough as the *kali purum*, rubbed to the part in the ordinary way, would have produced.

For many years I have been in the constant habit of making issues after this fashion; and as it appears to me with the following advantages over the common method:—

1st. It is a much less painful proceeding than the ordinary method; few patients suffer much from it, and none of them complain of the torture which an ordinary caustic issue inflicts.

2ndly. It is an exceedingly expeditious plan. In hospital practice an assistant has every thing prepared previous to the visit, and the issue is made in a surprisingly short space of time.

3rdly. It is, in my experience, much more efficacious than an issue put in by incision, as recommended lately by one of your correspondents.

From what cause it may be, I cannot pretend to say, but the *potassa cum calce* in powder, varies somewhat in strength in the shops, and therefore I am careful in using a new specimen for the first time, to commence with a thin stratum of the powder. If the phial be fitted with a ground glass stopper, and kept in a dry place, the same powder will last for years; if exposed to the influence of the atmosphere, however, being highly hygrometric, it soon becomes unfit for use.

I learned this method of issue-making many years ago from an esteemed medical friend, who resides at Pau, and who assured me that it was very commonly practised by the French.

FONTICULUS.

To the Editor of the Dublin Hospital Gazette.

SIR,—Your correspondent, "Medical Student," will find himself answered both as to derivation and meaning by consulting Hooper's Medical Dictionary, article "Noma."—Yours, W. S. B.

To the Editor of the Dublin Hospital Gazette.

SIR,—If your correspondent, "Medical Student," in the "GAZETTE" of February 1st, had taken the trouble to open Holbyn's "Dictionary of Medical Terms," at page 211, he would have seen the following paragraph:—

"NOMA, (*נמא*, to eat,) water-canker; a form of sphacelus occurring generally in children, and also called *stomacace gangrenosa seu maligna, necrosis infantilis, gangrenous aptha, &c.*"

Nothing could be clearer or more concise.—I remain, Sir, yours, A SENIOR STUDENT.

Feb. 4th, 1857.

To the Editor of the Dublin Hospital Gazette.

SIR,—In answer to the inquiry of a "Medical Student," in this day's number of your Journal, I would refer him to an useful old book, Turton's "Medical Glossary," where he will find "Noma" (or Noma) derived from the Hebrew word *Noma*, or from the Greek verb, *νμα*, I feed, and defined as a "phagedenic ulcer; also a species of herpes, whose humour corrodes the flesh."—I remain, Sir, your obedient servant, M. B.

Feb. 2nd, 1857.

COMMUNICATIONS have been received from Dr. Mayne; Dr. O'Donovan; Dr. Thorp; Dr. H. Johnson; Dr. H. Kennedy; Mr. G. Porter; Mr. Ross, &c. &c.

BELFAST BRANCH OF THE MEDICAL BENEVOLENT FUND SOCIETY OF IRELAND.—The stated Annual Meeting of the subscribers and friends of this local branch of the above most excellent and valuable Society was held on the 2nd instant, in the Library Room of the Belfast Medical Society, in the General Hospital, Frederick-street, Dr. PATTERSON presiding on the occasion. The meeting was influentially attended, as usual, and a very satisfactory statement made of the past year's proceedings, the interest attached to the operation of this branch being unabated, and the best results springing from its laudable and highly-important objects. The neighbouring towns, it was reported, continued to give their cordial aid in subscriptions and interest, and the names of Mr. Black, Ballymena; Dr. Filson, Portaferry; Dr. Thedford, Strangford; Surgeon Bruce, Antrim; and Dr. Musgrave, Lisburn, were especially mentioned as exerting themselves, in their several localities, with the best effect, on behalf of the Society, whose example, in this respect, was worthy of being generally followed. Dr. Gordon, Professor, Queen's College, Belfast, and Dr. Stewart, Hospital for the Insane, received the marked thanks of the meeting, for their unremitting services and attention, as Treasurer and Secretary, respectively, and were unanimously re-elected to the same offices for the current year; and the following Committee of Management was also appointed, viz.:—Dr. Stephenson (permanent president), Dr. Patterson, Dr. T. Thompson, Dr. Drennan, Dr. H. Ferguson, Dr. M'Gee, Mr. Browne, R.N.; Dr. M'Gowan, Carrickfergus; Surgeon Black, Ballymena; Surgeon Musgrave, Lisburn; Surgeon Bruce, Antrim; Surgeon Graham, Dromore; Dr. Filson, Portaferry; Dr. Thetford, Strangford; and Dr. Jamison, Newtownards. A deputation, consisting of Drs. Patterson, H. Ferguson, Gordon, and Mr. Browne, R.N., was appointed to visit the country districts of the branch, with the view of obtaining additional subscribers, and making more widely known the philanthropic purposes of the Society. A letter was read from the Parent Society, in Dublin, conveying their thanks for the zealous manner in which the business of this branch was conducted, and expressing the great value of the country branches generally, and the importance of increasing their number. After the transaction of some business of a routine nature, and receiving subscriptions for the current year, Dr. Patterson vacated the chair, and the meeting separated.

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CASE OF ACUTE ULCERATION OF THE INTESTINES IN TYPHOID FEVER,

FATAL BY PROFUSE HÆMORRHAGE.

By DR. M'DOWEL,

Physician to the Whitworth and Hardwicke Hospitals.

The following case is illustrative of a form of disease not often met with in this country, and which ran its course with unusual rapidity.

Case.—The patient was a remarkably fine-looking young man, 26 years of age, who was admitted into the Hardwicke Hospital, January 10, 1857. He was a person in comfortable circumstances, well fed and well clothed, so that he was not exposed to those external influences to which bad types of fever are so often referred, at least among the poorer classes. We learned that the symptoms of fever had existed for 12 days, but so slightly that the patient had not been obliged to keep his bed until three days previously. At the time of his admission there was nothing to excite any apprehension, or to lead us to infer the existence of any marked lesion. On admission, and for two days after, the ordinary symptoms of continued fever were present: there was slight cough; the pulse was 112; the skin was warm, but not inordinately so; the tongue was disposed to be dry; the surface was free from eruption; the mind was a little confused, and the patient raved some at night, but slept a good deal. It is particularly to be observed, that neither diarrhoea nor abdominal tenderness existed.

On the third day after admission (fifteenth day of fever) a few scattered papules were observed over the abdomen; the eyes were clear and bright; hearing unaffected; no sordes on the teeth. In these particulars, and in the absence of any marked signs of depression, the case was quite unlike one of ordinary typhus. On the evening of the same day (fifteenth day) excited delirium, closely resembling that of delirium tremens, set in, which continued, but with diminished violence, during the next day; on the evening of that day (sixteenth

day) profuse hæmorrhage occurred from the bowels; a very large quantity of fluid blood, of a dark colour, was passed at the chair; and subsequently so much came away as to soak through the clothes and bedding to the floor. The following morning (seventeenth day) the patient was greatly sunk; his voice was weak; face and lips pale; pulse small and rapid; abdomen free from tenderness; tongue dry. He was perfectly conscious, and answered all questions rationally. Turpentine was directed to be given in 20-drop doses, and small quantities of brandy in cold water.

A little grumous blood, mixed with feculent matter, was passed during the day, but during the night the hæmorrhage again occurred, profusely and suddenly. In the morning (eighteenth day) he was in a dying state; pulse too rapid to be counted; tongue dry and black; surface bedewed with cold, clammy perspiration; eyes bright and intelligent; but the voice was so weak that he was unable to speak so as to be understood. The stimulants were continued, and, contrary to all expectation, the patient lived for 24 hours. During this period there were one or two natural discharges from the bowels, unmixed with blood.

Examination of the body, six hours after death.

—The surface of the body was pale and exsanguineous. *Abdomen.*—The liver was healthy. *Spleen.*—Slightly softer than natural, and of moderate size. *Kidneys.*—Enlarged and soft; one weighed 9½ ounces. The stomach and upper portion of the intestinal canal were healthy, but the lower 30 inches of the small intestines, as also the cæcum, presented all the characteristic appearances of "typhous ulceration." The cæcum presented the most incipient condition of that affection, in the form of small greyish elevations. On some of these a minute point of ulceration was visible; in others the ulcer had made greater progress, and presented small cup-like cavities. In the small intestine were ulcers of different sizes, the largest being the size of half-a-crown; all presented an oval outline, with elevated thickened edges. Almost the entire of the mucous membrane of the lower

end of the ilium was destroyed, but higher up the ulcers were confined to that portion of the intestine opposite the attachment of the mesentery. No spots showing incipient disease of the Peyerian glands were found in the small intestine. At the highest point to which the disease had extended the ulcers had attained a considerable size: the rapidity of the ulcerative process seemed to be indicated by this fact. In many places not only the mucous, but even the muscular coat, had been destroyed, and at one point the serous membrane had almost been penetrated. The mesenteric glands were considerably enlarged, and in some of them a whitish deposit (not pus) was found. The intestines did not contain any blood, nor were there any small coagula in any of the ulcers, to denote the special source of the fatal hæmorrhage. *Thorax*—The tissue of the heart was firm, and looked healthy; the left ventricle was closely contracted. The lungs presented numerous bright petechial spots on their surface, and a section showed numerous small dark spots of extravasated blood in their parenchyma.

I have somewhat minutely detailed the preceding case, as its importance seemed to deserve more than a mere passing notice. The latency of the abdominal lesion, and the suddenness and profuseness of the hæmorrhage, constitute its more remarkable features.

The attack of "nervous delirium" on the fifteenth day depended, probably, on the rapid development of the intestinal lesion; whilst, on the other hand, the intensity of the nervous symptoms would have masked any evidences of enteritis which might otherwise have existed. At the same time, a depraved blood, partly, perhaps, the result of absorption of the vitiated fluids of the intestinal ulcers, might produce a similar train of symptoms; and of such an altered condition of the blood, the ecchymoses on and in the lungs are to be regarded as evidence.

The appearances in the intestines presented the full pathological history of typhous ulceration; the enlargement of a Peyerian gland, and elevation of the mucous membrane by sub-mucous deposit; ulceration of the summit of the mound thus formed, in order to eliminate the morbid material; lastly, sloughing of the mucous membrane over the whole extent of the diseased gland, and in some places the ulcerative process rapidly destroying even the muscular coats, and by opening the blood-vessels, giving rise to one of the most serious accidents of such a lesion.

Death directly the result of hæmorrhage in typhoid fever is undoubtedly rare; but somewhat similar cases will be found in Dr. Ormerod's Clinical Observations on continued Fever—(vide Cases 21, 22). I am indebted to my friend, Dr. Hudson, for an acquaintance with these cases.*

* Dr. Abercrombie narrates a case in which the hæmorrhage proved fatal in four hours.—*On the Stomach and Bowels*, p. 261, 3rd edition.

ON VESICO-VAGINAL FISTULA.

By JAS. H. SAWYER, M.D.,

Master of the Coombe Hospital, and Professor of Midwifery in the Original School of Medicine, Peter-street.

(Read before the Obstetrical Society, January 31, 1857.)

The number and variety of operations suggested for the cure of Vesico-Vaginal Fistula, are palpable evidences of its intractable nature; indeed, it has been justly considered one of the opprobria of obstetric surgery; and one of our best standard authors, after placing before the reader the numerous plans suggested for its cure, concludes with the following remark:—"In the majority of cases, I fear we shall find but little benefit from any operation; and yet it is pitiable to see the poor sufferers going from hospital to hospital, undergoing painful examinations, and willing to submit to any operation to relieve them from the inexpressible distress so graphically pictured by Dr. Churchill in the following passage:—*The escape of urine is attended with so marked and irrepressible an odour, that the patient is placed out of the pale of society; obliged to confine herself to her own room, she finds herself an object of disgust to her dearest friends and attendants; she lives the life of a recluse without the comforts of it, or even the consolation of its being voluntary.*"

My opportunities of observing this affection, in connexion with the Coombe Hospital, have been, fortunately, rare. I have notes of five cases during a period of 11 years. In one woman, from the country, who applied at the dispensary, the great extent and size of the fistula deterred me from attempting any operation.

In three, the actual cautery was applied several times; succeeding in one, and giving considerable relief in the others, by enabling them to retain a moderate amount of urine for some hours. Of course, this plan should not be attempted if the aperture be larger than the calibre of a full-sized catheter. It requires some dexterity to apply the canterizing iron quickly and lightly, to avoid sloughing, and the consequent increase of the aperture. Various other agents for canterizing have been recommended, viz., nitras argenti, liquid nitrate of mercury, and galvanic heat as recommended by Mr. Marshall of the University College.

Dr. Blundell and Mr. Porter, of this city, had each a successful case, from dividing the entire meatus up to the fistula, somewhat analogous to the operation for fistula in ano. I presume the fissure in their cases must have been much lower than we ordinarily find it.

I shall merely advert to *Jobert's erythroplastic operation*, as I think no British surgeon of the present day is likely to imitate him; the operation of dissecting an oval flap of integument from the inside of the thigh, and inserting it into the walls of the fistula, previously made raw—must have been

tedious, painful, and as results proved, most uncertain.

The suggestion of *closing the vagina* (except in elderly females) is a very serious consideration; and I should think, a well-moulded plug of sponge, covered with gutta percha or thin bladder, would equally answer the purpose.

Modern surgeons have placed most reliance on the *operation by suture*, first suggested by Roonhuyzen; and the various modifications proposed, at different times, in Great Britain and on the Continent, would fill a volume, some of them remarkably complicated, and not unattended with risk of life. In this country, Mr. Hobart, of Cork, has apparently had the greatest success. He must have had many more opportunities than, I am happy to think, the present practice of midwifery would afford, at least in Dublin. He thus writes to Dr. Churchill, in 1839:—"I beg to state, that many cases of vesico-vaginal fistula came before me during the past 15 years; many cured; some relieved; and others not at all benefited. I think there were from 10 to 15 perfectly cured." Very different, however, was the experience of the late Abraham Colles, as also quoted by Dr. Churchill:—"I have repeatedly tried the common interrupted suture; but though I have by this means lessened the orifice, I have never succeeded in closing it entirely." And this was the result under very favourable circumstances. He also alludes to the complications of after-hæmorrhage to a great amount, fever, hectic, &c.; and indeed, I think an attentive consideration of the structure of the parts concerned in this affection would lead us to the conclusion, that everything was opposed to the process of union, at least if attempted in the ordinary way, as in hair lip or cleft palate, by paring the edges, and drawing them together by the interrupted suture. The thinness of the mucous walls of bladder and vagina, the small amount of cellular tissue interposed, and the difficulty of preventing the acrid urine from insinuating itself between the edges of the wound, combined with the retracting influence of the muscular coat of the bladder, preclude the possibility almost of union by adhesive inflammation; consequently, we find that most of the recent operations are based upon ingenious efforts to overcome or palliate those difficulties. Foremost in these efforts have been our American brethren. But I cannot refrain from selecting a passage from Van Buren's Translation of Bernard's and Huetts's Operative Surgery. It is a specimen of *genuine tall talking*. After enumerating Dieffenbach, Blandin, Jobert, &c., and giving scarcely a passing glance at British surgery, he thus sums up:—"The text shows us all that French surgery (indeed, I may safely say European surgery) has achieved for this very troublesome affection. It literally amounts to nothing; because there are no broad principles of treatment laid down, and no successes demonstrated. It is otherwise with American surgery. The labours of our

countryman, Dr. Marion Syms, leave nothing to be desired in the treatment of this heretofore incurable affection."—A brief inquiry into these boasted *broad principles*, and the *successful results*, may be interesting; and, quoting from the latest writer on the disease, Dr. Bozeman, of Montgomery, Alabama, (January, 1856,) I present the following summary:—

In Europe.

Wutzer, of Germany, cured 3 out of 18.

Jobert, of Paris, cured half.

Mr. Henry Earl, of London, cured 2 in 30.

Mr. Baker Brown, operated 10 times in 3 cases; 1 successful—failures, 9 to 1.

In America.

Dr. Hayward, Boston, operated 20 times in 9 cases, 3 successful—failures, 17 to 3.

Marion Syms, cured about half.

Dr. Bozeman, Alabama, operated 7 times on 4 patients—all successful.

The extraordinary success which the two last-named writers claim, has made me most anxious to investigate the peculiarity of the *modus operandi* by which such fortunate results have been obtained. Both commence by paring the edges of the fistula; with this difference, that Dr. Bozeman bevels the edges, upon the vaginal aspect, to a greater extent than is recommended by Dr. Syms, thus ensuring larger surfaces for apposition; both use annealed silver wire, secured by being passed through perforated shot; the point of difference is, that Dr. Syms passes his ligatures through holes in two cross-bars of either polished silver or lead, and then secures them by clamps of shot. On the other hand, Dr. Bozeman passes the wires through the apertures of the button, and then clamps them through shot, as Dr. S. first suggested. Dr. Syms first arms a long spear-pointed needle with a silk thread, and introduces it half-an-inch anterior to the scarified edge, deeply, but without touching the mucous lining of the bladder, entering into a corresponding spot on the other side of the fissure, and emerging into the vagina, half-an-inch above; to each silk suture he attaches a piece of wire 18 inches long, and pulls the silk until the wire occupies its place; then passes each wire through the hole in the cross-bar above; clamps them by split shot, compressed between a strong forceps; then does the same to the inferior cross-bar, fixing the shot, and drawing each wire sufficiently tight, previous to clamping, by compressing each shot. Dr. Syms asserts that this suture, if properly applied, never ulcerates out, having always to be removed. He leaves it as long as ten days. Now let us hear Dr. Bozeman. He writes (page 12):—"The question is, does not the clamp suture itself often irritate and cut out?" So much for his boasted suture. Secondly—For his original position; I found it positively intolerable to my patient. Thirdly—With regard to Dr. Syms' self-retaining

catheter. I admit it is ingenious, but not essential. A long flexible gum-elastic catheter can be easily fixed, and with less probability of irritating the bladder. Lastly—We have his vaginal speculum, which, while depressing the recto-vaginal septum, is calculated to throw reflected light on the opposite wall.

I shall next turn to Dr. Bozeman's button suture. The bright idea struck the Doctor, while buttoning his waistcoat, just as the apple struck Sir Isaac Newton's head. I have formed a similar model, that you may judge whether it is likely all the advantages will be attained which the doctor asserts. (*Vide* page 22 of Dr. Bozeman's pamphlet).

It appears to me that this suture is more likely to irritate and cut out than Dr. Syme's. In fact, it must act like so many points of the common interrupted suture. That the button proves a barrier against the percolation of urine, except in a case of double fistula, is doubtful; if the margins are in proper apposition, it is unnecessary; and if not, it is on the wrong side. It may, as Dr. B. asserts, protect the wound from either menstrual or leucorrhœal discharge; but a cautious surgeon would not operate if either were present.

I have dwelt somewhat on Dr. Bozeman's operation, because Mr. J. Baker Brown, of London, one of the first obstetric surgeons of the day, has brought forward a successful case, cured in 14 days, by this new mode of operating; and, *en passant*, he had two great advantages; first, the small size of the fistula, only admitting an ordinary director; secondly, the disease having occurred only two months prior to the operation: and I am persuaded he would have had equal success, and in half the time, had he operated according to Mr. Maurice Collis's plan, which I have very great pleasure in submitting to you. I claim for it the following advantages:—First—Facility of execution. Secondly—Probability of speedy union by the first intention. Thirdly—The prominence of the vesical flaps forming an admirable barrier to the urine insinuating itself. Fourthly—Comparative freedom from hæmorrhage. And lastly—If it does not succeed, there will be no increase of the fistulous aperture, as after other plans. The following passage from the late Mr. Liston's lectures, bears forcibly on this point:—"All might appear to go on well for eight or ten days; but, at the expiration of that time, the wound would probably be found to have been enlarged by having been interfered with, and would become larger and larger every time the attempt at cure was made." The accompanying sketches, taken from a dissection made by me, show both the *modus operandi* and the effect of the operation on the vesical and vaginal aspects of the fistula. Having made an aperture in the vesico-vaginal septum of similar dimensions to the fistula on which I operated, I separated the vaginal from the vesical lamina, and introducing four sutures through the vaginal flaps, I secured them on the bars of gutta percha used in the operation; as the threads are

tightened, drawing together the vaginal margins, a similar approximation of the vesical flaps takes place, thus ensuring an apposition of at least five lines in breadth of surface favourable for adhesive union, and, at the same time, affording a protection against the urine infiltrating between the edges of the wound.

DR. SAWYER'S CASE OF VESICO-VAGINAL FISTULA.

On the evening of the 17th of last May, I was sent for to the Coombe Hospital, in the absence of Dr. Ringland, the Master on duty, and, for the first time saw the subject of the following case.

Fanny Wilkinson, 24 years of age, remarkably small, and very excitable; married 15 months; first child. Admitted into the labour ward at 3 o'clock, p.m., on the previous day. She stated that labour had set in on the 15th, and that the waters had come away before her admission. On examination, the os was found fully dilated; head presenting; pains strong and frequent. On the ensuing day, as she had not made progress, Dr. Kidd, the assistant to the Masters, was sent for. He promptly introduced a catheter, though with considerable difficulty, owing to the pressure of the head on the pubes. Having relieved the bladder, and finding no urgent symptoms, he directed that he should be sent for, if symptoms of constitutional irritation should arise before his return.

I saw her at 11½, p.m., in consultation with Dr. Jameson, and found her in a state of exhaustion, with quick feeble pulse; irritable stomach; the external parts were tender, hot, and dry. Under these circumstances, and as the head had remained stationary upwards of 19 hours, we decided at once to terminate the labor. I could not hear the fetal heart, but as the placental soufflet was evident, and the pupil on duty assured me he had distinctly heard the fetal tick a short time previous, I was reluctant to resort to the perforator. I succeeded, with some difficulty, in introducing the blades of Churchill's forceps obliquely, and after considerable effort, extracted a large male fetus. The patient made a good recovery in all points, with the exception of suffering from incontinence of urine, which set in about the fifth day after the operation. The formation of a vesico-vaginal fistula was ascertained; but, as her general health was impaired, she was directed to try change of air, and to return to the hospital after two or three weeks' sojourn in the country.

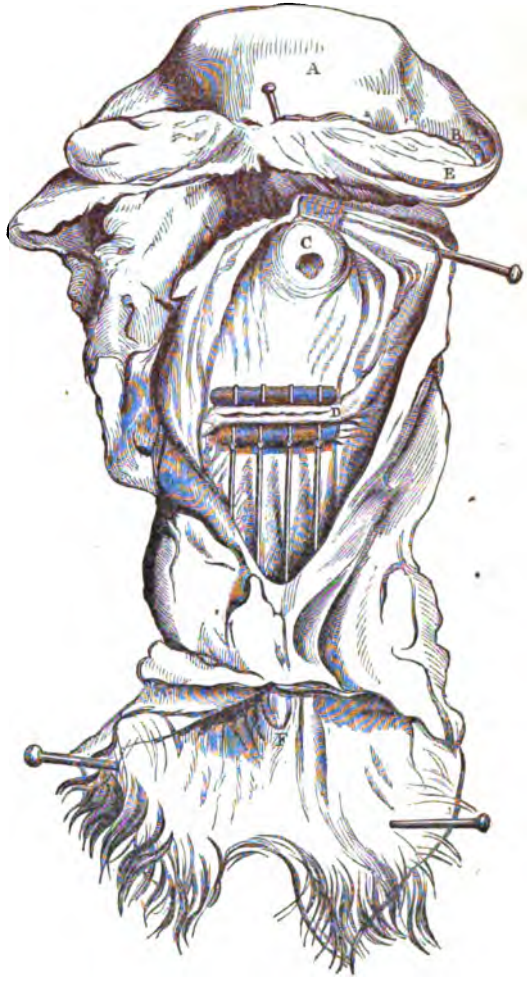
She was re-admitted on the 1st of July, 1856; and a transverse oval aperture about eight lines in its long diameter, permitting the fore-finger to be passed through it, was ascertained to exist immediately above the neck of the bladder. The narrowed condition of vagina, combined with the soreness resulting from extensive excoriation, made the examination very difficult. She complained, that the moment she turned in the bed,

PLATE I.—VESICAL ASPECT.



A, Interior of the Bladder. B, The Fistula, (the edges raised somewhat above the level of the mucous membrane. C, Upper orifice of Meatus Urinarius.

PLATE II.—VAGINAL ASPECT.



A, Uterus. B, Ovary. C, Os Tincæ. D, Fistula. E, Fallopian Tube. F, Lower orifice of Meatus Urinarius.

or assumed the erect posture, the urine flowed. She said her life was miserable; that she was unable to earn her bread; and would gladly submit to any operation. I had the advantage of the advice and valuable suggestions of my respected friends Drs. Maurice Collis, Churchill, and M'Clintock; also my colleagues, Drs. Ringland and Kidd; and the Hospital Consultants, Drs. Jameson and Wilmot; and decided on operating after Mr. Collis's plan, on the 15th. In the mean time, I had made a set of dilators, better adapted to keep the vagina well opened. I directed borate of soda wash; and also, with my colleagues' assistance, fully tried the injection of carbonic acid gas, and Dr. Hardy's chloroform bellows; but instead of diminishing sensibility, such aggravated suffering, with increased contraction of the vagina, was induced, that

I was forced to put off the operation until the 25th. Two days prior to that date, I cautiously dilated the vagina with plugs of prepared sponge, smeared with extract of belladonna, which proved in this case an admirable anæsthetic. After trying different positions, I found the lithotomy posture most convenient, and accordingly, on the 25th, having previously cleared out the bowels, and secured the hands and feet, I proceeded to the operation. It was intended to operate under chloroform, but after a few inspirations, the sudden irregularity of the heart's action compelled us to desist.

Two dilators were passed, and pressed obliquely upwards and outwards; then the third, pressing down on the recto-vaginal septum, enabled me to get a view of the fistula. A full-

sized catheter passed through the urethra, and pressed downwards and forwards, kept firm the posterior margin, and prevented the bladder from coming in contact with the knife. With Baker Brown's knife I carefully split the vesico-vaginal septum at the posterior lip, to the extent of three lines, carrying the knife carefully around the commissure, and keeping close to the vesical surface. I then did the same to the lower and anterior lip, but with greater difficulty, as its aspect was turned from me. The constant welling of blood and urine compelled me to work very slowly. I then syringed with cold water, which in some degree repressed the bleeding; and with the same needles used by Mr. Collis I introduced four ligatures of ordinary housewife-thread, at intervals of three lines, carefully avoiding penetrating the vesical mucous surface. I secured the ligatures over two bars of gutta serena, instead of gum-elastic, as used by Mr. C., as it is not corroded by the vaginal secretion. I was most cautious not to draw the threads too tight, and thus prevented strangulation of the lips embraced between the bars. The operation lasted about half-an-hour. She was then placed in bed on her face, her body well supported by pillows. A long gum-elastic catheter was passed and secured, and one grain of opium was directed to be given every third hour. On the fourth day I examined, and was gratified to find the margins of the wound in perfect apposition, and no suppuration. I cut the ligatures, but did not remove them until the following day, that is, the fifth from the operation. The union was complete, but I did not venture to withdraw the catheter or act on the bowels until the eighth, when the following mixture was directed:—

Olei Ricini ʒvj.

Tinctura Rhei ʒliij.

Confect: Amygd: ʒlv.

Aqua Cinnamomi ad ʒvi.—st. ʒi. 2dis horis.

This acted gently. On the eighteenth day she was walking about, able to retain the urine, and her only annoyance was a tendency to pass water frequently. This gradually subsided, and on the 14th August she was discharged in perfect health, and is at present in a good situation, and, as she declares, as well as ever she was in all her life.

HOSPITAL FOR CONSUMPTION, BROMPTON.—This hospital now contains 230 beds, and application has been made to some of the different medical examining Boards in the Metropolis to recognise attendance on it as part of the medical practice required of candidates for examination. Favourable replies have been received from the University of London, the Apothecaries' Company, the Navy Medical Department, and the East India Company.

At the last meeting of the Edinburgh Royal Physical Society, it was resolved to memorialize Government to purchase Mr. Hugh Miller's valuable collection, to be added to the new National Museum, now in the course of formation in Edinburgh.

CASES OF

ACUTE PARTIAL GLOSSITIS, WITH OBSERVATIONS.

By HENLEY THORP, M.D., F.R.C.S.I.,
Of Letterkenny.

Case 1.—On 4th March, 1854, Barney Daley, a healthy-looking boy, æt. 12, presented himself at the Letterkenny Dispensary. About eight days previously he had taken a draught of hot broth, which produced much pain, and blistered his tongue. On the same day a friend, with the view of relieving the pain which affected the organ, blew a quantity of pepper into his mouth. This proceeding greatly aggravated the symptoms, and prevented him from taking anything but drinks; his articulation, at the same time, became very difficult and painful.

The left side of the tongue, from its base to within half-an-inch of the extremity, is greatly swollen; its right side and apex are free from any tumefaction whatever. The swelling is convex above and below, firm and painful when pressed; and appears to extend a little beyond the median line into the substance of the organ on the opposite side. The dorsum of the tongue is covered with a quantity of whitish, pasty-looking mucus. There is much fullness below the jaw on the left side, and some of the cervical glands are enlarged and tender. In making an incision along the upper surface of the swelling, I unexpectedly opened an abscess, containing about a drachm and-a-half of healthy purulent matter. The patient had well-marked rigors. In a week the tongue was restored to its original volume, size, and functions.

Case 2.—Mary Jane Buchanan, æt. 8. This child's complaint first commenced seven days ago, with a sore throat, occasioned, as is believed, by a severe wetting. Four days afterwards the tongue became affected. The left side of the organ is greatly swollen, hard, and painful; the swelling is very convex and prominent superiorly, and appears to extend across the median line, so as partially to involve the opposite side. It, moreover, projects downwards towards the floor of the mouth, and produces a fulness beneath the jaw externally. The dorsum of the tongue is covered with a thick coating of a white, pasty-looking substance. A similar secretion adheres to the corresponding part of the palate above. The right side of the organ is thin and flaccid; its edge depressed beneath the level of the lower teeth. The left margin, from base to apex, is, on the contrary, round and thick, and very much raised above its ordinary position; so that the whole tongue appears rotated on its long axis. Phonation and deglutition are greatly interfered with. There are neither hoarseness nor difficulty of breathing, nor febrile disturbance; there has been no rigor.

A longitudinal incision made along the dorsum of the tongue, into the most prominent part of the

swelling, was followed by a copious discharge of blood, and a speedy reduction of the size of the organ.

Case 3.—August 17th, 1855.—Patrick Logan, æt. 25, a dealer, attended at the dispensary. Three days previously, after much fatigue and sweating, he was exposed to cold, and in the evening felt great soreness of the cervical glands. In the course of the night his tongue also became swollen and tender. Patient speaks with difficulty and pain; he is unable to swallow solids, and can only get fluids down in small quantity, and with great efforts; his tongue is enlarged, and its extremity protruded between the incisors; the left edge and base are free from swelling and hardness, but the remainder of the organ is firm, brawny, and exquisitely tender, more especially inferiorly. The apex is blunt and broad; the right sublingual gland is enlarged and painful, as also several of the lymphatic ganglia below the jaw on the same side. The patient has not slept for two nights, and complains of agonizing pain in the neighbourhood of the right ear. Saliva escapes in considerable quantity from his mouth.

Three longitudinal incisions were practised along the dorsum of the tongue, with the immediate effect of disgorging its blood-vessels and greatly reducing the tension and swelling. He was desired to use a wash containing nitrate of potash and borax, and purgative medicines were prescribed. The patient did not return to the dispensary.

A very remarkable fact in the history of inflammatory affections of the tongue is, that of their being occasionally partial, or limited to one side of the organ. Whether the distribution of blood-vessels which do not freely communicate at opposite sides, or the existence of the fibrous septum, which divides its substance along the median line, is better adequate to afford an explanation of this circumstance, I shall leave for others to determine. The foregoing cases are good examples of acute partial glossitis. Although, from the description given, it might appear that in two of the patients the inflammatory action had involved more or less both sides of the tongue, still I do not believe such to have been really the case; it appeared to me that the firm intumescence of the affected portion had, in these instances, by exerting eccentric pressure on the opposite, or sound half of the organ, apparently reduced its size rather than spread to its substance. It is not my intention to enter upon the consideration of the causes capable of giving origin to this affection; it is sufficient to say, that exposure to cold was the exciting cause in two of the cases just detailed, and that in these cases there were sore throats, and the cervical glands were also affected; in the other patient the disease was the direct consequence of the application of a scalding fluid. Except in cases of acute general swelling of the tongue, complicated with cynanche, or involving

the glottis, the disease, so far as I know, is not attended with great risk, and when properly treated, generally terminates in resolution; when suppuration does occur the matter usually forms in the loose cellular tissue around the sublingual and submaxillary glands, beneath the membrane of the mouth; however, in *Case 1*, an abscess existed in the substance of the tongue, and close to its upper surface. I have only to add a word as to treatment. When incisions are practised, (and they afford a simple, prompt, and effectual means of reducing the swelling by relieving excessive congestion,) they should be confined to the dorsum of the organ, the larger blood-vessels are distributed along the under surface, and might give rise to hæmorrhage difficult to restrain. I remember, when a student in Dublin, seeing a case of acute glossitis: it occurred in a dropsical patient, who also suffered from an intercurrent pustular affection of the face, which spread into the mouth, and produced the swelling of the tongue; a surgeon made a deep incision in the inferior surface of the organ near its edge; a profuse bleeding ensued, under which the patient almost succumbed. In severe cases, more especially if there be hoarseness, cough, or any symptom indicating an extension of inflammatory action to the glottis, it may be necessary to apply leeches in large numbers to the neck, or even to take blood from the arm. Such cases would also require the exhibition of purgatives, tartar emetic, &c., and the strict pursuance of antiphlogistic measures. Graves recommended the application of leeches to the tongue itself—an excellent practice in cases attended with an unusual amount of tumefaction, and where incisions have failed, or cannot be efficiently employed.

PATHOLOGICAL SOCIETY OF DUBLIN.

A meeting of the Pathological Society was held on Saturday, January 24th,

Mr. FLEMING, V.P., in the Chair.

Aortic Aneurism.

Mr. G. PORTER exhibited an Aneurism of the Aorta, from a man aged 37. He had always worked hard at his trade, which was that of a shoemaker; he was very fond of walking, running, and other physical exercise; and in the habit of singing very often. At one period of his life he had been a very intemperate character, and had taken two or three courses of mercury. For the last six months he suffered from a pain under the left scapula; it was not, however, very severe, and was unaccompanied by any cough, nor did it interfere with his breathing. A few days before his death he had been running a race with a friend, from which exertion he felt no inconvenience. Early on the morning of the 30th of this month, his wife

was awakened by a loud shriek, and found him dead beside her.

On opening the body after death, there were two aneurismal sacs observable at the bend of the aorta, a little above the place where the pericardium invests this vessel; one of these sacs had burst, by a very small opening, into the cavity of the pericardium, and so caused death.

Dr. HENRY KENNEDY exhibited a specimen of
Thoracic Aneurism,

which he said might prove of interest, when contrasted with the one just exhibited by Mr. Porter. The patient, a woman 60 years of age, was admitted into Cork-street Hospital three weeks since, labouring under a very severe attack of suffocative catarrh, attended by much fever. Dr. K. observed, that this was not the first instance of the kind he had seen. Once before, he had witnessed a case which had passed through fever at a time when aneurism in the chest also existed. The present case had long had a chronic cough, liable at times to exacerbation, and this latter was now present. The signs of aneurism had commenced, as he was informed, about two years before, by pain referred to the right side of the chest, and by paroxysms of dyspnoea, at first slight, but gradually increasing. The patient never had dysphagia, nor cramps. Oedema of the arms prevented the possibility of feeling any pulse at the wrist. There was no venous turgescence about the root of the neck. A tumor, the size of a large turkey egg, presented above the right mamma. It was placed obliquely; was solid to the feel; and communicated to the stethoscope a single violent impulse; unattended by any bruit; nor could any be heard over the heart. The dyspnoea was very great, the patient being unable to lie down for many days before death; but this seemed due to the state of the lungs rather than any effect of the aneurism. On examination after death, the aneurism was found to arise from the aorta, just where it turns to form the transverse portion of the arch. From this it had passed slightly upwards, and entirely to the right; and the sac, full of half-coagulated blood, lay behind the second, third, and fourth ribs, portions of which were carious. The sac itself was remarkably strong in every part, and, as far as it was concerned, would not have given way, most probably, for months. Between the sac and the heart the aorta was very much diseased; the vessel being two inches across, and its coats greatly thickened, and exhibiting, internally, large plates of osseous structure. The valves of the aorta and mitral orifice were healthy. The heart itself was nearly double the average size; it was flabby in its texture, and had more than the usual amount of fat, chiefly limited to the right side.

Dr. Kennedy alluded particularly to the place of pointing. In all the cases of aneurism of the arch of the aorta, which he had seen in females, there was this to be remarked, that they con-

stantly passed towards the right side, and pointed somewhere about the right mamma; whereas, in man, the same disease more frequently engaged the left side of the chest.

Benign Osteosarcoma.

Professor R. W. SMITH presented a series of three casts, illustrative of the growth of a benign osteosarcoma of the femur. The following was the history of the case: Mathew Dalton, æt. 30, was admitted into the Richmond Hospital, June 18th, 1852, with a large tumor, seemingly caused by an expansion of the shaft of the right femur. He stated that the disease had existed for three years and a half, and began with pain in the knee, which gradually extended up the thigh; the femur then began to enlarge a little above its centre; the growth of the tumor was slow, and the pain was of a trivial character. When he came into the hospital the limb measured, round the centre of the tumor, twenty-six inches; the integuments were healthy and moveable over the tumor, which presented an even and globular surface; his health was perfect in all respects, and he walked well; there was no glandular disease nor enlargement of veins in the vicinity of the tumor; everything, in fact, indicated the benign character of the morbid growth.

Besides this principal tumor, several other osseous growths were observed in different parts of the body, there was a small one over the outer ankle of the right side, it was applied by a broad base to the end of the fibula, and was moveable; there was one above the inner ankle, and another of larger size, and irregular on its surface, directly below the inner side of the head of the tibia, and again another on the dorsum of the ilium. There were, likewise, others in nearly similar situations on the left lower extremity, one on the dorsum of the foot, a second over the outer ankle, a third below the inner edge of the head of the tibia, and a fourth just above the inner condyle of the femur.

He remained in the hospital on this occasion for a year and ten months, when he returned to the country and resumed his usual labour in a farm; at the end of three months he came back to Dublin, and was again admitted on the 23rd November, 1854. With the exception of an increase in the size of the tumor, which, with the limb, now measured 32 inches in circumference, there was no change in his condition; his health was still perfect, and he could still walk well. On this occasion he only remained three months in the hospital; he went home in February, 1854, and did not come back until the 9th of January, 1857. The tumor had now attained a prodigious size, measuring three feet four inches in circumference, and one foot eight inches in longitudinal extent; it had extended upwards, so as to conceal the tumor on the dorsum of the ilium. Certain portions have become prominent, but it is everywhere

firm, and equally resisting throughout; in some places there is a distinct feeling of elasticity, and here and there over its surface, the finger detects in the bony shell deep sulci, which form the channels of dilated veins. It is impossible to detect the course of the femoral artery. The motions of the hip-joint are obstructed, and the knee and leg swollen and hard; the motions of this articulation are also much impaired, and it is the seat of a considerable degree of pain. The skin covering this immense tumor, though stretched to the utmost, has, as yet, scarcely any morbid attachment to it, but here and there a blush of redness has appeared, and there is a general tendency in it to retain for a short time the impression of the finger. No change has taken place in any of the other tumors, but his general condition is much altered for the worse; he has lost flesh, rests badly, and does not relish his food as before; he suffers more pain than formerly in the tumor, and complains of thirst and a troublesome cough.

With respect to the nature of this immense tumor, whatever action of a malignant character may ultimately be established in it, I think that at present, notwithstanding its enormous size, we are warranted in believing that it still possesses the characters of a benign growth; its slow, though gradual and steady increase, the absence of glandular contamination, the comparative integrity of the patient's health, the trifling amount of pain, the man's ruddy complexion, and his cheerful state of mind, and especially the co-existence of so many other tumors, as to the benign nature of which no doubt could be entertained, are all circumstances which forbid our arriving at any other conclusion than that this prodigious growth is a benign osteosarcoma. I know of no other tumor affecting the long bones, which attains to so vast a size, and yet is consistent with such integrity of the general health, and so complete an exercise of the functions of the limb.

ABSTRACT OF THE PROCEEDINGS OF THE BELFAST CLINICAL AND PA- THOLOGICAL SOCIETY.

SESSION 1856-7.

Eleventh Meeting—continued.

Dr. MOORE introduced a patient on whom he had operated for *Talipes Equinus* six weeks previously. The patient had walked on his toes, his heel elevated from the ground above four inches. Dr. M. cut the tendo Achillis, and applied a bandage; some days afterwards he divided the plantar fascia and the opposing tendons; a bandage was again applied. The patient now was able to walk well on the sole of his foot, and the muscles of the calf were becoming developed. Dr. M. used no splints, and recommended that the knife should be inserted beneath the skin, and its edge

merely pressed against the stretched tendinous structures, which are readily severed; thus nerves and arteries escape being injured. Dr. M. never met with hæmorrhage, tetanus, or any unfavourable result, by such mode of operating. Dr. M. had formerly operated on a girl (the patient's cousin) for a similar defect, with equal success.

Dr. Moore exhibited

A Cyst containing an oleaginous fluid,

about the size of a goose's egg, which he had removed from the lumbar region. Dr. Moore also related the history of

A case of Abscess of the Pharynx,

which, pressing forward the uvula and tonsils, and resting on the epiglottis, caused suffocative and other urgent symptoms. With the long bent trocar and canula, he evacuated about three ounces of fetid pus, affording immediate relief.

Dr. PIRRIE presented the Lung, &c. &c., of a patient who had died with

Pneumothorax,

and related the following history of the case and *post mortem* examination. Thomas Campbell, æt. 18 years, was admitted into Frederick-street Hospital, on the 18th of August. He stated that he had been ailing for a period of 18 months, but much more so for the last six. On examination, the heart was found beating to the right of the sternum, and there were the other decided evidences of pneumothorax of the left side. The patient lingered on until the 29th of December. *Post mortem*.—The body was much emaciated; on opening the left side of the thorax, air gushed out. The heart was found lying to the right of the sternum, the left margin of the left ventricle being fully half an inch to the right of the right margin of the sternum. The left side of the thorax had the appearance of an enormous cavity, containing about half-a-pint of fetid purulent matter, and was lined throughout by a soft, pulpy false membrane, about quarter of an inch thick. The lung, which was firmly compressed, and bound down to the spinal column, contained indurated tubercles. The right lung was universally adherent to the thoracic walls, and filled throughout with tubercular matter in all its various stages.

Twelfth Meeting, January 17th.

Professor FERGUSON, V.P., in the Chair.

Dr. JOHN MOORE read the history of a

Case of Scarlatina occurring during the puerperal state.

On Sunday, November 16th, 1856, I attended Mrs. M'L., æt. 28 years. It was her first confinement, and she gave birth to a female child, after about 10 hours' illness. There was nothing unusual in the labour, except that the cord was only a span long. On Monday her pulse was 110.

Tuesday, I found that she had spent a restless night; pulse 120. There was a considerable degree of feverishness present; there was, however, no abdominal tenderness; the lochia continued to flow; she had passed urine freely, and the bowels had acted. I ordered her powders containing *hydrarg. c. creta*, and *Dover's powder* night and morning, with nitre during the day. Thursday I found her covered with the eruption of scarlatina. The attack seemed a very mild one, as there was a total absence of any tendency to sore throat. The uterus manifested no signs of being implicated, and at this period my prognosis was favourable. She was nursing the infant, which manifested no symptom of the disease. Friday morning I found that the baby (which I had left in good health on the evening previous) was dead. At twelve o'clock it had been placed in bed with the mother; in about two hours the nurse was awoke by her in a state of delirium, and found the child dead where the mother had overlain it. Dr. Halliday visited my patient in consultation, and from the absence of any throat or uterine complication, was also inclined to take a favourable view of the case. Saturday there was little change in the symptoms, but on Sunday she sank into a comatose state, and died the eighth day after her confinement, and the fourth after the appearance of the eruption. On the Thursday preceding her confinement she had gone to visit a family where she had lived as a servant, and where one of the children had been ill. She remained all night, and slept with the child, which afterwards turned out to be suffering from scarlatina, though at this time the eruption had not appeared, and she did not see it afterwards. As scarlatina is a disease of so frequent occurrence in children, and as parturient females are most frequently to be found where children are, it is a complication which we ought to be prepared to meet with. There are several points in the case which appear to me interesting. 1st—The period at which the disease was communicated, viz., before the eruption had appeared. Patients are said to be much more likely to communicate scarlatina in the latter than in the early stages. 2nd—The period of incubation—from Thursday until the appearance of the eruption on the following Wednesday. 3rd—The absence of what we might *a priori* expect, any uterine affection. The fatal termination, notwithstanding the absence of what, in this disease, is the most fatal of its symptoms, viz., the throat affection. And last, but not least, the freedom of the child from the disease; for on the evening of its death there was not a trace of it, although it was nursed by the mother, who was at the time covered with the eruption; showing that those poisons which, when introduced into the system either by inhalation or inoculation, act injuriously, will, when taken into the stomach, prove harmless. But I cannot tell how the infant escaped, with the mother's blood circulating through its veins,

charged with the combustibles that were so soon to explode and destroy her.

Mr. BROWNE introduced a patient on whom he had operated for

Congenital Cataract.

He was 21 years of age at the time he presented himself to Mr. B.; since then he had undergone two operations—one with the needle, and the second with the canula forceps—to remove a piece of the capsule. The result has been very satisfactory, as he can see near objects very well by the aid of $2\frac{1}{2}$ -inch glasses, and distant objects by means of a 4-inch focal power. The patient already begins to know surrounding objects, of which he had hitherto been quite ignorant. He intends to learn to read and write. Mr. Browne also presented a patient, aged 66 years, from whom he had *extracted* a cataract. The patient had been operated on a fortnight previous to his appearing before the Society. The section of the cornea had healed so completely, that the cicatrix was scarcely discernible. The cornea, Mr. Browne remarked, was quite healed on the fifth day. Vision, in this case, was good, and improving rapidly.

Dr. MOORE introduced a patient suffering under *Cancer, engaging the Breast, Axilla, and Scapular Region.*

The arm and hand were swollen to a great degree. The patient concealed the existence of the disease in the breast for more than nine months, and when she first sought advice, there was a tumor the size of a turkey egg. At that time (above one year since) she was urged to allow an operation, but refused; and since then the disease increased to its present extent.

Dr. PATTERSON referred to the treatment of cancerous ulceration by the application of finely powdered sulphate of zinc, as recently suggested by Professor Simpson. The following is the formula:

R: Zinci Sulph: Exsicc: ʒj.

Axungia ʒii.

Misce et fiat ungt.—

Or, Zinci Sulph: Exsicc: ʒj.

Glycerina ʒi.

Misce et fiat ungt.—

Either of these being applied and renewed, until a healthy surface is obtained.

Dr. MOORE also exhibited a

Diseased Ankle Joint,

affording an example of gelatinous degeneration, with ulceration of cartilages, which he had removed from a girl 23 years of age. Patient has gone on satisfactorily, the wound having healed by the first intention. He presented a morbid mass, about 1 lb. weight, removed from the labium of a prostitute. The disease had its origin, some 12 years since, in a hardened extensive syphilitic ulcer, and had increased until it attained its present dimensions.

The SECRETARY read the following communication from Dr. HALPIN, of Cavan, on

Retroversion of the Uterus.

"In the Abstract for 1st November there is a report of a case of retroversion of the uterus, read by Dr. Pirrie. As this is a subject to which I have devoted a good deal of attention, I felt very much interested in that case. If I might offer an opinion, from impressions derived from similar instances in which I have been engaged, I would say that the woman might have been relieved at the earliest stage at which we have her history, and probably the process of gestation would have gone on to the full period. I do not know whether you ever met with a paper that I read on this subject before the Dublin Obstetrical Society, January 2nd, 1840. It is reported in the *Dublin Journal of Medical Science*, vol. xvii. page 67 (old series). The method I had recourse to was extremely simple—inflating the pelvis. It restored the uterus immediately to its normal position. I have had very many communications from medical practitioners who have tried the means I recommend with the happiest results. Should any member of your Society meet with cases of retroverted uterus, he will find no difficulty in relieving them by this method. I had a case of anteverted unimpregnated uterus, in which I was enabled to restore the organ to its natural position without difficulty, by inflating the vagina." Dr. Charles Purdon described the mode of inflating—viz., by placing an Indian-rubber bag, with a tube attached, in the vagina, and then distending it with air.

Dr. BRYCE related the history of a case of retroversion. The uterus was not restored to its normal position. The period of uterogestation was prolonged for nearly 12 months, when the patient died, delivery not having been effected.

Thirteenth Meeting, Saturday, January 24.

The President, Dr. M'GEE, in the Chair.

After the minutes were read, Dr. HALLIDAY introduced a patient, the subject of

Hepatic Abscess,

and related the following history of her case. Rebecca Carvel, aged 26 years, about two years since applied at Dispensary, stating that up to three months previously she had enjoyed good health, when the catamenia ceased to appear—from what cause she could not state. She now complains of oedema of the lower extremities. This, notwithstanding that she remained under treatment for some months, went on to general dropsy. She sought admission into Union Hospital, where she remained but a fortnight, the urgent symptoms passing off. She returned to her work at the mill, at which she continued only three days, the swelling having reappeared. Again she came to Dispensary; and finding she improved under the

treatment adopted, resumed her work, at which she continued for five months, taking no medicine whatever. At this time she became much worse, and in addition to her former symptoms, complained of frequent chills, with cough, and pain in the right side, shooting up to the shoulders. She now passed into Frederick-street Hospital, where she was cupped and blistered over the affected side. Here she remained nearly three weeks, and finding no improvement, left. About five weeks ago Dr. H. was again called on to visit her, and found the liver very much enlarged, extending up into the thorax, protruding across the epigastrium, and downwards near to the umbilicus. She had also general dropsy. Posteriorly the right side of the chest, for two-thirds up, was dull on percussion, with almost total absence of respiratory murmur. She had never expectorated blood, nor was the sputa at all pneumonic. At this time the pain, a little to the right of the epigastrium, was intense; and here the enlarged liver assumed somewhat a dome shape. The bowels were regular. She had no rigors, nor could fluctuation be detected. About one week after, on the 24th December, when dozing in her mother's arms, in the evening, she awoke, saying she had neither pain or ache; and on next morning she passed, by stool, a quantity of slimy matter, mixed with dark blood and pus. Up to the present the stools are of the same character, but not to the same extent. Her general health is improving rapidly. The enlargement in the right hypochondrium has almost disappeared; her dress now meets upon her, which before it would not do; but the dulness of the chest posteriorly remains in pretty much the same state. There is still, also, some cough, with slight oedema of the legs. The menses have not returned.

Professor FERGUSON drew attention to the contracted state of the lower part of the right side of the chest. He accounted for the dulness still existing posteriorly, by the presence of some amount of pleuritic effusion.

Mr. BROWNE presented a patient who had been introduced to the society about two years since, as affording a well marked example of an

Extensive Serpiginous Syphilitic Ulcer.

Great difficulty had been found in healing it. Fumigations of cinnabar directed to the ulcerated surface by means of vapour baths, and ten grain doses of iodide of potassium, had at last proved effectual. Mr. B. also exhibited a portion of the lower extremity of the Humerus, removed in performing the operation of excision of the elbow joint. The origin of the disease was attributed to injury, and a small cavity was detected in the diseased portion of bone, the probable seat of an abscess.

Dr. MOORE presented

A Cyst removed from the side of the Frænum.

It was about the size of a nutmeg, and was re

moved with a portion of loose skin. He remarked that he had never before seen a tumor of such a nature removed from the penis. It contained a clear glairy fluid, and was of six years' growth. Dr. M. also exhibited a small body about the size of a pea, removed from the anus. It had caused a gnawing uneasiness both before and after stool, which was quite relieved by the operation.

Selections from Recent Contributions

TO

PATHOLOGY AND PRACTICE OF MEDICINE.

Inflammation of the Cerebral Sinuses.—After disease of the internal ear has existed for a long period, a group of symptoms occasionally set in, bearing a close resemblance to typhoid fever, and ending fatally by coma. On dissection, it is found that the inflammation has extended from the petrous bone to the dura mater; and in some cases this membrane is ulcerated, and a communication is established, by a minute opening, between the diseased bone and the cerebral sinuses. An example of this lesion was presented to the Pathological Society, by Dr. M'Dowel,* a short time since; and a similar one has been witnessed by the writer, the symptoms being undistinguishable from those of typhoid fever. At other times the inflammation and suppuration extends by continuity over the membranes of the brain, and in others abscesses form in the substance of the hemispheres. Lebert has investigated the relation of these abscesses to the disease of the internal ear, and finds the connecting link to be inflammation of the cerebral sinuses. The transverse and the petrosal sinuses are those most frequently filled with pus. The cavernous and circular sinuses, the torcular herophili, and the jugular vein may become involved, and the inflammation may extend along the superior vena cava, even to the right auricle, as occurred in a very remarkable case, in the practice of the late Dr. Crampton.†

The ordinary symptoms of inflammation of the sinuses, according to Lebert, are the sudden supervention upon chronic otorrhoea of rigors, heat, accelerated pulse, loss of strength, oppression, and more or less general pain of the head, furred tongue, loss of appetite, thirst, in short, symptoms resembling the first stage of typhoid fever. The headache is more intense than in that disease, and generally soon becomes confined to one side. There is occasional delirium, generally of a quiet character. After a few days or a week symptoms of compression appear; the patient becomes indifferent and somnolent, and gradually passes into a comatose state, sometimes alternating with periods in which the intellect is unclouded, in the same way a paralytic condition is observed to alternate with a perfect control over the extremities. The face exhibits similar alternations on the affected side. Convulsive affections are rarely met with. The fever accompanying the disease presents an intermittent character, often marked by so much periodicity, that it has even been mistaken for genuine intermittent, and treated accordingly. These febrile paroxysms indicate the pyæmia which has supervened. The duration of the disease in 14 cases was, respectively, from 9 to 15 days in four, from 21 to 28 days in five, from 28 to 35 days in three, once in 37 days, once 42 and once 61 days.—*Virchow's Archiv, and British and Foreign Review.*

* See DUBLIN HOSPITAL GAZETTE, vol. ii., N. S., p. 117.

† See Reports of the Pathological Society of Dublin, vol. i., p. 4.

Blocking up of both Internal Carotid Arteries by Coagulum, and consequent death.—The patient was a woman, æt. 23, who for several years suffered occasional attacks of headache and epilepsy, not followed by any paralytic symptoms. After a more than usually severe and protracted headache, she was found lying in a state of partial insensibility, incapable of speaking distinctly, and paralysed on the left side. She was admitted into St. Thomas's Hospital, and died in four days, after a violent convulsive fit, followed by coma.

The anterior lobe of each cerebral hemisphere was softer than the posterior half, and this softening, which was but slight, extended back to the right hemisphere, as far as its centre, being most apparent in its convoluted portion. The right corpus striatum and the brain substance below and in front of it were softer than the corresponding parts on the left side, and somewhat softer than any other portion of the brain.

The vertebrals, the basilar with its branches, including the posterior communicating, were perfectly healthy, pervious, and empty of clot. The right internal carotid and the right anterior and middle cerebral arteries were distended with a softish coagulum, of a uniform light pink colour, completely filling them, and adherent throughout its whole extent. The parieties of the vessels, even where the coagulum adhered, appeared to be healthy. The left internal carotid and anterior and middle cerebral arteries were also diseased, but their condition was different. The internal carotid was contracted, and its channel filled with a white opaque membranous formation, which was so blended with the parieties, that it was difficult, if not impossible, to distinguish them from one another; at one part of the anterior cerebral artery this formed an opaque yellowish white enlargement, about the size of a grain of wheat, which, on section, was found to contain a cavity filled with a pulsile fluid. There was no blood in these vessels, and their walls beyond the seat of disease, both on the right and left side, were healthy. The softened portions of the brain, examined by the microscope, and compared with the apparently healthy portions, presented no difference in structure. The heart was healthy. There were no vegetations on the valves, and no sign of disease in them, or on any part of the endocardium. There were no old clots in the cavities. The aorta was healthy.

The reporters of the above case, Drs. Peacock and Bristowe, observe that its interest is increased by the fact, that while the right internal carotid and its branches presented an example of obstruction from recent coagulum, the same vessels, on the left side, presented a transformed clot, the product of a similar coagulum at a former period. The recent clot they consider, was produced by an inflammatory condition of the artery at the point of coagulation.—*Transactions of the Pathological Society of London.*

Two recently recorded cases of *Aneurism of the Aorta*, deserve a brief notice. The first, by Dr. Williamson, in the January number of the *Edinburgh Medical Journal*, presented a well-marked example of contracted pupil on the side on which the aneurism was situated, a sign to which the attention of the Profession was first directed by Dr. Gairdner of Edinburgh. The second was somewhat unusual in its mode of termination. The patient, a stout-looking servant girl, was found on the floor in violent convulsions. She died in 85 minutes, the convulsions continuing to the last. The body was examined at the instance of the authorities, and the head was opened first, in the expectation of finding there the fatal lesion, but nothing unusual was observed. The pericardium was found distended with a semi-solid clot. The heart's fibres were not ruptured. On tracing the aorta, from above downwards, with the finger, a small nipple-shaped sac, the size of a large bean, was felt on the anterior aspect of the aorta, and about three quarters of an inch above the valves; the summit of this small aneurism exhibited an opening the size of a crow-quill.

This resembles other recorded cases of rupture into the pericardium, in the comparatively slow termination. Whether from the small size of the opening (the aneurism being usually small), or from the inextensibility of the pericardium, or from both causes, a longer interval seems usually to elapse after rupture than when this occurs in other situations. Blakiston gives a case in which life continued for 10 hours. Dr. Stokes refers to a case in which, "owing to partial adhesions, probably of long standing, the dilatation of the sac of the pericardium was very gradual, and the sinking of the vital powers very protracted." The mode of death, by convulsions, was more unusual; collapse and extreme dyspnoea being more frequently noticed when death was gradual.

An interesting case has been communicated to us by Dr. R. M'Dermott, in which death occurred in his presence. The patient, who had previously suffered from severe angina pectoris, with palpitation, was attacked with acute pain in the cardiac region and dyspnoea. The respirations were 60 in the minute, and interrupted by most painful sobs. The cardiac region was observed to have become dull on percussion; his face became flushed, and after half an hour of frightful suffering, he died in a kind of tetanic spasm—the head bent back, the feet extended, and the hands firmly clenched. Dissection showed the pericardium filled with coagulated blood, which had escaped through a rent in the aorta, one-third of an inch in length.

Hydatid Cyst in the Lung.—We find mention of two recent cases of this rare affection. In the first case, by Dr. E. Montard Martin, Physician to the Hospital St. Antoine, the disease simulated pleurisy. The patient, a man aged 28, caught cold in the latter end of January, and having an attack of hæmoptysis, applied for admission into hospital in February, 1856. At this time the posterior surface of the thorax was resonant throughout, and the respiratory murmur mixed with mucous rales. Anteriorly, the right side was resonant throughout; the percussion was tympanitic at the left apex, to the extent of two fingers' breadth under the clavicle; the remainder of the side was dull—the transition to dullness abrupt—extending from the middle of the sternum to a line with the axilla. The heart was pushed downward, and towards the mesial line. There was no trace of respiratory murmur or of vocal resonance throughout the dull portion. Two days afterwards, an occasional amphoric blowing, distant and accompanied with feeble metallic tinkling, was audible in this part. Diagnosis: general bronchitis; circumscribed pleurisy, with effusion, limited to left anterior thorax.

After a brief absence from hospital, he was re-admitted on the 19th of March, when the dullness of the left side had entirely disappeared, and the heart had recovered its normal position. The respiratory murmur was perfect throughout the portion which had been previously dull. Posteriorly there was marked dilatation, with complete dullness, and absence of respiratory murmur. The diagnosis now made was general pleurisy and effusion, probably caused by rupture of the adhesions which had encysted the primary effusion. On the 2nd of April the patient expectorated an immense quantity of purulent liquid; and after repeated attacks of cough, attended with similar expectoration, he died asphyxiated, on the 6th.

The *post mortem* showed, on the left side, anteriorly, firm old adhesions, disposed circularly. With the exception of a small portion of the anterior surface, the entire lung was adherent to the pleura, and there was no trace of effusion. The volume of the lung was enormous, and it yielded the sensation of a pouch with thin sides, filled with fluid. In the attempt to remove it, the pouch gave way, and an enormous quantity of coagulated blood escaped, with the remains of an hydatid cyst. The cyst was developed on the upper lobe of the lung, and by compression had reduced the lower lobe to the thickness of about two centimetres.

The second case is given in Dr. Gairdner's Clinical

Notes (Ed. Med. Journ., Jan. 1857). The patient, aged 27, complaining of cough and expectoration, was admitted into the Royal Infirmary, July 20, 1856. Two years before admission he was confined to bed for a week with pain in the back and right shoulder. Six months afterwards this pain recurred, with cough, inability to move the right arm, and hæmoptysis. He at first spat up half-a-pint of pure blood; after this he spat blood occasionally, but on the whole continued well until a month before his admission, when his symptoms returned, and he lost appetite and flesh considerably. For some time after admission the case resembled one of ordinary tubercular disease; there was dullness on percussion over the right side anteriorly, with feeble respiration, and vocal thrill and resonance were much impaired. Some time after admission the following peculiar physical signs were noticed:—The right front was completely fixed in respiration, and there was a distinct fulness of this side, from the second to the fifth rib, with obliteration of the intercostal depressions. The dullness on percussion was absolute over this prominence, and all respiratory and vocal phenomena were absent; above it there was faint tubular respiration. The lower zone of the chest was dull on percussion, but not visibly enlarged; and breathing (faint and tubular) was audible at the lower part of the back.

At this period Dr. Gairdner considered the alternative diagnosis to lie between cancer of the middle portion of the right lung and a very peculiarly-placed pleuritic effusion circumscribed by adhesions. It was considered impossible to form a decided diagnosis without further evidence.

No important change occurred until the 20th of November, when there was a return of copious hæmoptysis, attended with the discharge of a pint or more of a watery fluid, said by the nurse to have come from the stomach. After this the expectoration became more decidedly purulent than before, and acquired a marked gangrenous fœtor; the bulging of the chest anteriorly entirely disappeared. At this time the diagnosis of hydatid cyst of the lung was made by Dr. Gairdner, from the presence of portions of the membrane in the sputa. The physical signs now were those of a cavity; faintly tympanitic sound on percussion, highly tubular breathings, with hollow crackling. He died on the 29th of November, and on dissection, a cavity six inches in diameter, was found in the upper lobe of the lung, containing the remains of a solitary hydatid cyst. The walls of the cavity were, at several points, in a state of gangrenous suppuration, and the tissue around it was much condensed and indurated.

A third case is abridged from a paper entitled "Some Cases of Hydatids in the Human Subject; by H. Krabbe, Candidate at Frederik's Hospital," published in the *Hospitals-Meddelelser*, Copenhagen, 1856, p. 131.—S. P., a servant girl aged 30. Several of her family had suffered from, and her parents had died of, thoracic disease, of the nature of which more accurate information could not be procured. As a child she had been liable to convulsions, probably epileptic, to which the female members of her family were said to be disposed. For a time she had been given to drink, but for the last few years she had abandoned this vice. Nine years ago she gave birth to a child. For the last three or four years she has presented symptoms of an affection of the chest, palpitation of the heart, shortness of breath, and cough without expectoration.

Five days before her admission, she suddenly fell when at work, and got what she called cramps in her chest. Her countenance was blue; she was almost pulseless; and lay in a state of unconsciousness, with laboured respiration, for half-an-hour, when, after venesection, she revived. In the afternoon large sinapisms were applied to the chest and back. She was obliged to keep her bed; was pale; felt exceedingly languid; and for several nights following raved and was very unmanageable. She had no appetite; was thirsty, short-

breathed, and coughed occasionally rather violently. For the last few days she expectorated a very fetid, but not particularly abundant, purulent fluid. She had no pain in any part.

On her admission into hospital, on the 28th of June, the temperature of the skin was natural; respiration 36, somewhat laboured, attended with action of the *alae nasi*. She coughed but seldom, and then in fits, expectorating a fetid, frothy, yellowish purulent mucus, untinged with blood. She could lie equally well on either side. The pulse was 120; the impulse of the heart was tolerably strong; dulness on percussion in the pericardial region was normal; the cardiac sounds were pure. On the right side the sound, on percussion, was everywhere less clear than on the left. On the left the respiration was puerile; on the right it was everywhere, particularly under the clavicle, weaker than on the opposite side. Posteriorly, irregular large rales were here and there heard; on the right side the feeble respiratory murmur, which was amphoric beneath the scapula, was everywhere accompanied by a metallic tinkling, particularly distinct when the patient coughed. At half-past ten, p.m., she fell into a state of unconsciousness, which continued until her death, which took place at midnight.

The body was examined 36 hours after death. Around the inferior part of the right lung was a tolerably thick layer of soft, plastic, gelatinous exudation, infiltrated with serum. The whole upper portion of this lung was firmly adherent to the wall of the thorax. After the lung was taken out an incision was made in its side, whereby a cavity as large as a child's head, situated in the upper part of the lung, close to its posterior surface, was opened. The interior of this cavity was uneven, yellowish-grey, and most closely resembled the inside of an old tuberculous cavity. In one place it was found to communicate with a middle-sized bronchial branch, running along its wall, by an opening through which air could be blown, under water, by means of a tube introduced into the right bronchus. Besides air, the cavity contained some ounces of greyish-yellow purulent fluid; and at the bottom was found a collapsed white sac, lying free in the cavity, without any connexion with its walls. This sac had a fissure-like opening, a couple of inches in length, supposed to have been produced in conducting the *post mortem* examination—an occurrence which might easily have taken place, as this sac was so rotten, that when lifted up it fell by its own weight into several pieces. It was elastic, but did not bear any great distension without breaking. In the collapsed state it measured about five inches in diameter. It was formed of a milk-white membrane, a line in thickness. On the outer side it was smooth, and covered with a thin gelatinous layer, yellowish by transmitted light, which was loosely adherent, and easily separable as a membrane. The interior of the sac was much less smooth; it was covered with slight elevations and depressions; here and there were scattered point-like cavities; and in some places were white round knobs, almost as large as peas. In addition, there were some fold-like prominences, reaching to half-an-inch in length, formed by the inner layer of the sac separating from the outer. In the cavity of the sac were found, in addition to a number of detached knobs, similar to those observed on its inner surface, two small sacs—one of the size of a hazel-nut, the other somewhat less; they were flaccid, bluish by transmitted light, and contained a fluid. The membrane of which they were formed was much thinner than that of the large sac, but was of the same nature. The greater part of the substance of the upper lobe of the right lung was compressed, but the entire of the anterior edge still consisted of healthy pulmonary matter, on the surface of which small emphysematous spots were here and there observed. No middle lobe was found distinct from the upper lobe. In the inferior lobe, posteriorly, a small part was in the state of grey hepatisation. The tissue of the left lung was healthy. The larynx presented no

abnormality. The pericardium contained a small amount of reddish fluid. The heart was of the ordinary size; in the right ventricle was a large, tough, fibrous coagulum, yellowish by transmitted light, which, inferiorly, was entangled in the trabeculae and papillary muscles, and superiorly, passed for some distance into the pulmonary artery. The left ventricle contained a small, dark coagulum of blood. The heart presented no other abnormality. The liver and other abdominal organs exhibited no morbid appearance.

The clear fluid found in the larger of the two small sacs was examined under the microscope, and proved to contain echinococci. Of these about half-a-score were observed, and when moderately magnified, were seen as clear, slightly yellowish bodies, of a roundish form. The so-called calcareous cells were evident, as was also the chaplet in the centre; the suckers, on the contrary, were not perceptible. A wreath of hooks was observed more accurately with compression and a strong magnifying power, when there were reckoned 28 hooks—in 14 larger and 14 smaller—in regular alternation. In two places, however, the circle was interrupted by an open space, and it seemed as if in each of these situations the hooks had fallen out; so that the wreath had probably consisted, when perfect, of 32 hooks, which appear moreover, to be the most usual number with the echinococci. The alternation of large and small hooks, in which the French helminthologist, Livois, has called attention in the echinococci, was here particularly striking, and is worthy of special observation, as it is not always evident. (*See Eschricht, in the Bibliothek für Lager, 1854, 4de Band, page 25.*)

[On examining, next day, the contents of the smaller of the two small sacs, the author failed to discover any echinococci, though some detached hooks were observed.]

We copy the following interesting Case of *Acute Tuberculosis*, by Baron Gustaf von Düben, and the discussion which ensued thereon, from the *Transactions of the Swedish Society of Physicians*.—Hr. Düben read the history, and exhibited the lungs, of a person who had died in the Seraphim Hospital of acute tuberculosis; and he, at the same time, described the results of the microscopical examination of the morbid products found in the lung. The granulations, which were everywhere similar, and about equal in size, appeared to be formed of the distended air-vesicles, into which a whitish grey substance was densely packed. This mass consisted of a viscid hyaline substance, connecting the other structures. The latter were, first, small, strongly refractive, opaque, amorphous granules; secondly, the tubercular corpuscles, described by Lebert, of from $\frac{1}{100}$ to $\frac{1}{150}$ of a millimetre in size, some with, others without, nuclei; some round, others angular; in the latter case generally assuming a round form on the addition of dilute acetic acid, or by the continued action of distilled water; thirdly, epithelial cells, in large number, from the vesicles and from the bronchial tubes. Of these cells, some were entire, others were broken, almost all were filled with granules, and their nuclei agreed, in all their physical and chemical properties, with the tubercular bodies lying among them. The author considered, for these and other reasons, that the so-called tuberculous mass consisted of epithelium, separated in enormous quantity, and in the condition of fatty transformation, described by Reinhardt; in support of which view he quoted Henle's description, and read a letter from Schroeder van der Kolk.

Hr. Malmsten, who had seen some of Hr. Düben's preparations, considered that the examination which he had made might lead to important results; but, at the same time, he thought that the development of tubercle in other parts, should be investigated before coming to a decided opinion on the subject.

Hr. Berg had, in his clinique, long directed his attention to the important derangements which the excessive exfoliation of epithelium in the lungs is capable

of producing; and he referred to the state of things in capillary bronchitis, as strongly corroborating Hr. Düben's views.

Hr. A. Retzius observed, that if an abnormal exfoliation of epithellum was, in every instance, sought for as the cause of tuberculosis, difficulties would be encountered, for epithellum is found almost everywhere in the blood vessels and lymphatics, on serous and mucous membranes, &c.

In answer to a question by Hr. Santesson, Hr. Düben mentioned, that the fat developed in cells and nuclei of cells appeared to be difficult of solution in ether, but dissolved best in boiling ether, and that it had little tendency to collect in drops.

We copy the following remarkable Cases of *Pneumatoxis* occurring in patients the subject of *Typhoid Fever*, by Jeffrey A. Marston, M.D., Staff Assistant Surgeon, from the *Medical Times and Gazette*:—Among the cases treated at the Malta Military Hospital, we had many of typhoid fever; and two cases occurred, in one of which, unquestionably, a gas was developed in the blood during life. Unfortunately, I have to trust to my memory, having only noted the circumstance among the various medical notes preserved.

The first case noticed occurred in a private of a line regiment, suffering from typhoid fever, with the characteristic abdominal symptoms. He had been thirteen days in hospital, and was evidently sinking. The surgeon who attended him observed, in the afternoon visit, that the left side of the neck, and greater portion of the thoracic parietes, appeared much swollen, and upon pressure they were found to be distinctly emphysematous. Having been called to the patient a few days previously, the surgeon was able to state positively the absence of this affection then. The man died about five minutes after the first observance of this symptom; and, upon examination, it was discovered that air was mixed with the blood of the venous system generally, existing in the right side of the heart, liver, hepatic and portal systems, renal system, spleen, and the viscera generally. The lungs were most carefully examined, and no trace of rupture could be found anywhere; but they were emphysematous (the lobular variety), about their margins and apices. No gas existed in the pleural sacs, nor in the pericardium. The tumor over the chest and neck was plainly emphysematous and crackling, and easily reduced by multiple punctures. The bowels were tympanitic. The other pathological appearances were those of typhoid fever, viz., softening of the spleen, ulceration and enlargement of Peyer's glands, some injection of the mesenteric glands, a very fluid condition of the blood, and a softened and uncontracted condition of the left ventricle of the heart.

The second case occurred in a private of the East Kent Militia, stationed at Malta, aged 20, admitted with all the symptoms of typhoid fever, who died of that disease on the 9th of September, 1856, after being 11 days in hospital. During life he had a well-marked rubeoloid eruption, symptoms of ulceration of the ileum, with hypostatic pneumonia. About 40 minutes before death he used a bed-pan, and it was noticed that his body about the neck and chest appeared enlarged, and "cracked" on pressure. He had used no exertion, nor any straining. The post-mortem rigor ensued, as usual, quickly after death, and was slight. He died at three, a.m., and his body was examined at half-past 12, p.m., same day, nine hours and a half after death. The weather was not remarkably warm, and the body had not undergone the slightest decomposition. The external surface about the chest and lower part of the neck was occupied by a diffused tumor of a clearly emphysematous nature; and, as in the other case, the swelling gave exit to air by puncture, more or less subsiding at the same time. Upon raising the sternum, it was found that the lungs were emphysematous, not collapsing much by the pressure of the external air. The

pericardium was distended with air completely; the left ventricle, and no portion of the arterial septum contained any; but the right side of the heart was distended. Air existed also in the pulmonary artery; none was found in the pulmonary veins. The lungs were much congested at their base, probably chiefly the result of position, but no false emphysema, or rupture of the pulmonary tissue existed anywhere. The jugulars also contained air. The blood was frothy in the hepatic venous system, from admixture with a gas; but no air appeared to exist in the portal system. The veins of the spleen and kidneys also contained air: both the venæ cavae contained air; indeed, this condition was general to the venous system. Tympanitic distension of the abdominal viscera existed also. The lesions were those of typhoid fever, as enlargement and ulceration of Peyer's glands, similar exactly to the last case.

J. P. Frank describes some similar cases, but does not, that I am aware, hazard any opinion as to the pathological cause of its production. Dr. G. O. Cless, in an interesting paper on the pathological development of gas in the blood, has collected 13 cases—two observed by himself—of typhoid fever apparently identical with our own cases. Sudden death occurred in all the cases he has narrated.

This pathological condition, in every case hitherto recorded, has been confined to the venous system. After enumerating the various sources from which it might arise, he concludes that it is spontaneously developed from the blood itself, and proposes to term it "Pneumothomia." The death was not sudden in the last case narrated by us.

These remarks *On the Detection of Lead in the Urine in cases of lead poisoning*, by Edward Sieveking, M.D., F.R.C.P., Assistant-Physician to St. Mary's Hospital, &c., are also from the *Medical Times and Gazette*.—The masterly memoir by M. Melsens, on the Treatment of Metallic Poisoning by Iodide of Potassium, which appeared some time since in the *British and Foreign Medico-Chirurgical Review*,* has caused the iodide of potassium to be more generally employed for the purpose of eliminating metallic poisons that have combined with the tissues of the body. The views promulgated by M. Melsens were supported by strong experimental and clinical evidence, and so far as my opportunities of witnessing and treating cases of metallic poisoning have since enabled me to judge, I should be disposed fully to corroborate the remarks of M. Melsens with regard to the eliminative power of the iodide of potassium in these cases. I have, in fact, in numerous cases of lead poisoning, to which I may take another opportunity of adverting more fully, found that the iodide of potassium sufficed for the cure of the patient. Dr. Parke,† since the publication of the memoir of M. Melsens, has published a paper on the elimination of lead by iodide of potassium, in which he filled up a lacuna left in the memoir, by giving the proof, that during the administration of this remedy the lead actually passed off by the kidneys. The following may be offered as a further corroboration of the fact that the lead is eliminated by this channel. It were well if we were able to demonstrate, with equal certainty, the mode in which organic poisons are eliminated by iodide of potassium, than which we possess no more certain and trustworthy alternative.

A plumber, aged 34, was admitted into St. Mary's Hospital, under the care of Dr. Chambers, on the 7th January, 1857. He had had colic three or four times previously, but had experienced no symptoms of saturnine paralysis. On the 7th of January he was suddenly attacked with epileptic fits. He had a succession of fits, which lasted for thirty-six hours. When I saw

* January, 1853.

† British and Foreign Medico-Chirurgical Review, April, 1853.

him on the 14th of January, he stated that he had no recollection of anything that happened from the time of his admission into the hospital to the 12th of January; that he woke up with severe headache occupying the entire head, with vertigo, and found that he had lost the power of moving the left leg and the right arm; the left arm and the right leg continued normal both in regard to sensation and motion. There was decided diminution of sensation in the affected limbs, and the right hand was in a permanent semiflexed condition, with very little power remaining of opening or closing the fingers. On first recovering consciousness the people in the ward seemed to him as small as dolls, and the opposite side of the room seemed to be sunk forty feet below his own level. These erroneous impressions he was conscious of at the time, and they disappeared in four days. The urine was very scanty. There was a marked blue line round the margin of the upper and lower gums. I would remark that on testing the sensibility of both hands with an aesthesiometer, (an instrument which I have had constructed for the purpose of measuring the amount of sensibility in different parts of the body), I found no deviation from the normal standard on the 16th of January, as the patient was able with the tips of the fingers of either hand to distinguish a distance of less than 1-10th of an inch; at the same time that the patient, when I first saw him, complained of want of sensation in two of the limbs, the same limbs were very tender, and a slight pinch caused pain, so that we had to deal with that singular perversion of the sensitive function to which the term *anæsthesia dolorosa* has been applied, though without regard to the etymology of the words. This susceptibility to pain remained after the ordinary tactile sensibility appeared to be restored. My friend, Dr. Markham, who had charge of the patients of Dr. Chambers, kindly at my request prescribed on the 10th of January, the iodide of potassium in 10 grain doses three times a-day. A rapid improvement was perceptible. The amount of urine rapidly increased; but, although on two occasions after commencing the iodide of potassium the urine of at least twelve hours was tested for lead, none was found.

The fact that Dr. Bernays himself, the able clinical lecturer at St. Mary's Hospital, kindly charged himself with these analyses, will be a sufficient guarantee that no lead was present. I again ordered the urine to be collected from the 20th to the 21st of January, and although probably only about one half of the urine secreted had been preserved, owing to the remainder having been discharged in defecation, I obtained 860 cubic centimeters, of a reddish-yellow hue, and turbid. This was evaporated down nearly to dryness; I boiled the residue with nitro-hydrochloric acid, and filtered. The filtrate, on the addition of sulphide of ammonium or of sulphuretted hydrogen, gave a copious precipitate of the sulphuret of lead.

As my only object in publishing this case is to offer a further proof of the eliminative action of the iodide of potassium in lead poisoning, I will dwell no further upon it; otherwise the occurrence of the epileptic seizures, the peculiar optical illusions, and especially the paralysis of opposite members of the upper and lower half of the body, would offer an ample theme for discussion.

SOLVENT PROPERTIES OF GLYCERINE.—Advantage is being taken of the solvent and preservative properties of glycerine, in the preparation of medicines, both for internal and external use, and of various essences for culinary purposes. Glycerine approaches very nearly to diluted alcohol in its solvent power. It is supposed to possess the same power of supporting nutrition as cod liver oil, and to be more easily digested in many cases. This, however, requires the confirmation of experience. Many specimens have been sent us of me-

dicines prepared with it, such as iodide of iron, quinine, iodide of quinine, carbonate of iron, iodine, tannin, perphosphate of iron, &c. The culinary preparations are essence of cloves, essence of cinnamon, lemon juice, lemon flavouring, &c. The flavour is well preserved. It is extremely probable that in many cases glycerine will supersede alcohol as a solvent and preservative.—*Medical Times and Gazette.*

MEDICAL PROFESSION IN FRANCE IN 1856.—According to the *Annuaire Médical et Pharmaceutique*, just published, there are distributed over 7,662 communes in France, 11,268 Doctors of Medicine, 6,765 *Officiers de Santé*, and 5,550 *Pharmaciens*. Compared with 1855, there is a slight increase in the number of Doctors and *Pharmaciens*, and a sensible diminution in that of *Officiers de Santé*.

Correspondence.

To the Editor of the Dublin Hospital Gazette.

SIR,—May I again trouble you in reference to the two letters which appeared in your last issue, with respect to the etymology and signification of the word "*Noma*." Both "*Senior Student*" and "*M. B.*" may be strictly right in their alleged meaning; but the terms "*Stomacace*" and "*Cancrum oris*" are, I think more properly applied to the gangrenous disease of the fauces and mouth; the word *Noma* being at present restricted to the same inflammation occurring in "the vulvæ of young girls" (Hooper), and synonymous with *cancrum vaginæ*. I cannot find it anywhere alluded to in surgical works as disease of the mouth; and I believe it has now, by common consent, in medical nomenclature, descended to the vulvæ.—I am, Sir,

Your former correspondent,
W. S. B.

Feb. 17, 1857.

COMMUNICATIONS have been received from Dr. M'Cormac (Belfast), with enclosures; Mr. Barker; Dr. Moore; W. S. B.; Dr. Conolly (London); Dr. O'Connor (London); Dr. Daly (Hull); Dr. Hayden; Dr. Johnson (Belfast); Dr. Nicolls (Longford).

Dr. Mansfield's communication is in type.

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A CASE OF

SYPHILITIC DISEASE OF THE STERNUM,

ATTENDED BY SIGNS OF INTRA-THORACIC TUMOR.

By OWEN DALY, A.B., M.D. T.C.D.

Lecturer on the Practice of Medicine in the Hull Medical School.

My attention has of late been much drawn to the subject of Thoracic Tumors, by having met with a most interesting case, in which all the symptoms of pressure inwards, and of serious thoracic disease were present. In the particular case to which I am now about to refer, the true nature of the disease was diagnosed, and was further verified by the treatment which I adopted, as the patient, by a steady perseverance in the remedies prescribed, was relieved of all the urgent symptoms of her disease, and finally perfectly recovered.

It is not my intention to enter upon any history of the symptoms usually present in cases of thoracic tumor, as they are fully detailed in all standard works upon diseases of the heart and great vessels, but to confine my remarks to a concise history of this case, and to a few brief remarks upon some of the most interesting points presented.

Early in the month of September, 1856, a married woman, aged 38, consulted me. She stated she had suffered from difficulty of breathing for the last seven or eight months, which had, during the last three weeks, increased to such an extent as to prevent her going to bed or lying down, as the attempt to do so always brought on a dreadful feeling of suffocation. She also complained of dysphagia, which had likewise increased so much as to prevent her swallowing any solid food, and of severe pain of the upper part of the sternum.

Upon examination, the following symptoms were noted. The countenance was expressive of great anxiety and distress; the eyes were prominent and staring; the face was puffy, and of a dusky hue, more particularly the nose and lips; the respiration was stridulous (stridor from below), and laboured; the slightest exertion—even the act of speaking—occasioned violent fits of cough-

ing, and aggravated all her sufferings. Upon examining the chest, a tumor, or prominence, or bulging with conical elevation, in the centre of the upper and right portion of the sternum, implicating the sternal end of the clavicle, and extending over a space having a diameter of between two and three inches, was immediately observed. When viewed in front no movement was visible; but on looking at the tumor sideways, or from above downwards, a very slight motion was detected, which was very perceptibly transmitted to the hand when laid upon the tumor. On placing the stethoscope over the centre of the tumor, the first or systolic sound of the heart, and the passage of the air through the constricted trachea, were heard painfully clear and distinct; the second sound was absent; the voice was likewise intensified. By the term, "painfully clear and distinct," I mean to imply that the sounds appeared to be intensified, and to originate in the cavity of the tympanum itself. The heart's sounds were normal, although weak, and seemingly distant. The pulse in the left arm was natural, in the right hardly perceptible. Respiration was natural in the left lung, while in the right the respiratory murmur was feeble, and almost deficient. Upon passing a finger over the sternal end of the clavicle, and pressing downwards in the direction of the anterior mediastinum, a tumor of bony hardness and exquisite tenderness was detected, which seemingly occupied a position corresponding to the external tumor on the internal surface of the sternum, and which, by its pressure inwards, occasioned all the patient's sufferings. The seat and origin of the tumor being satisfactorily determined, it remained to diagnose its nature, which was happily effected; for while looking rather closely at the patient, a small tumor was observed on the forehead, partly concealed by her hair. It appeared firmly attached to the bone, and was quite hard, about an inch and a-half in length by half-an-inch in breadth, and had the appearance and character of a syphilitic node. On being questioned as to the length of time she had observed it, she replied, about two months, and

added that occasionally it was very painful, and had increased considerably in size during the last few weeks. Feeling convinced it was a syphilitic node, I told her so. At first, she stoutly denied ever having had syphilis, but finally admitted that she had suffered from an eruption on her chest and back eighteen months or two years ago. Acting under the belief of the syphilitic nature of the affection, she was directed to take five grains of blue pill every night, and five grains of iodide of potassium three times a day; the tumor to be painted night and morning with a strong solution of iodine.

She called to see me at the end of a week, and even in that short time, a visible and striking improvement had taken place in all her symptoms. She could speak with much less difficulty; the voice was not so hoarse, and there was a perfect absence of stridor so long as she remained quiet. She further stated, she had been able to lie down in bed the last two nights, which she had not been able to do for three weeks previous to consulting me. No visible change had taken place in the appearance of the tumors on the sternum and forehead. She was desired to continue the medicines, to apply a blister to the tumor of the sternum, and to repeat it. The blisters to be dressed with a mild preparation of mercurial ointment.

After an interval of a fortnight, I saw her again. The node on the forehead had nearly disappeared. The conical elevation of the sternum had considerably subsided; and, so far as one could judge, the internal enlargement of the sternum must have also considerably decreased, as all the urgent symptoms of pressure inwards were quite relieved. The internal tumor could still, however, be easily felt, and was very painful upon the slightest pressure.

Towards the end of October, she called a third time. The node on her forehead had altogether disappeared, and the external enlargement of the sternum was much less; it had, in fact, lost all the conical elevation it at first presented, and there remained only a slightly thickened condition of the parts. A corresponding improvement had also taken place in the intra-thoracic disease. All the distressing inward pressure symptoms had disappeared; the voice had regained its natural tone; the respiratory murmur had become much louder and clearer in the right lung; and the livid colour of the face had been replaced by a healthier hue. She was desired to continue the iodide of potassium.

Just before Christmas I had another opportunity of examining her chest. The internal tumor had considerably decreased in size, the decrease being very palpable to the finger, when pressed downward behind the clavicle; it was also much less painful when pressed. The external tumor was hardly perceptible. She expressed herself as feeling perfectly well, and free from all uneasiness and pain in the chest.

I now consider her as perfectly restored to health; as what remains of the internal tumor is

but the consequence of the great length of time the disease existed before being subjected to medical treatment; and I believe it will have no tendency to shorten her life.

The history of this case offers several very interesting topics for consideration, to a few of which I propose briefly to allude.

1st—The discovery of the true character and nature of the tumor was the result of mere chance. Had I not fortunately observed the tumor on her forehead, I do not for a moment suppose I should have been able to form a correct diagnosis of the thoracic tumors.

2nd—The position of the tumor on the internal surface of the sternum may, I believe, be considered as unique; for although syphilitic nodes are not uncommon upon the sternum, yet no one, so far as I know, has given a description of a tumor of syphilitic origin, springing from the internal surface of that bone, and giving rise, by pressure inwards, to all the symptoms of a frightful and incurable disease.

3rd—The second sound of the heart was absent, while the first or systolic sound was transmitted through the tumor with increased force and clearness. I do not attempt to offer any explanation of this very curious fact, and content myself with merely drawing attention to it.

4th—The pulse in the right arm regained its natural strength and force, and became equal to that in the left arm; and the respiratory murmur of the right lung also gradually became stronger and fuller as the internal tumor decreased, until at length no appreciable difference could be observed between the respiratory murmurs of the right and left lung. Lastly, the results of the treatment showed that the proposition laid down by Dr. Walshe—"that intrathoracic tumor is, of course, beyond the permanent influence of treatment," must be taken with some little limitation; while they, at the same time, proved the efficacy of the treatment which he states, is often followed "by astonishing temporary improvement."

I had an opportunity this day of making a careful examination of the woman, and the second sound of the heart was quite distinct. Both the remains of the internal tumor and the thickening left by the external enlargement of the sternum, have completely disappeared, I could not observe the slightest difference between the two sides; the pulse in the right arm and the respiratory murmur in the right lung do not differ in the slightest degree from the pulse and respiratory murmur of the opposite side. The only remains of the disease (if it can be called such) is a little pain on pressing heavily upon the articulation of the clavicle with the sternum. It is, perhaps, also worthy of observation, that I felt to day, for the first time, the right subclavian artery to beat, upon pressing a finger behind the clavicle.

25, Albion-street, Hull,
March 5, 1867.

CASUAL OBSERVATIONS IN PRACTICE.

By W. F. MONTGOMERY, M.D.

Late Professor of Midwifery, &c., in the School of Physic, in Ireland.

(Continued from page 19.)

The perusal of a case of more than ordinary interest, in the number of the DUBLIN HOSPITAL GAZETTE for February 15th, by Dr. O'Donovan of Belurbet, recalled to my recollection a case which came under my observation several years since, in which coma suddenly supervened upon jaundice occurring in a pregnant woman. The particulars I copy from my Case Book, written at the time.

No. 6.—Coma supervening on Jaundice with Ascites, in a Pregnant Woman; extraordinary difficulty in detecting Pregnancy.

"In April, 1829, I was requested to see a woman in the Meath Hospital. She was greatly enlarged by ascites, and considered herself to be in the seventh month of pregnancy. I could not, however, discover the child by the most careful examination, frequently repeated; but the uterus had evidently undergone the changes naturally consequent on impregnation. By the stethoscope I could gain no information.

"The woman had jaundice, and other evident symptoms of liver disease of long standing. In consultation with Dr. Douglas, it was deemed inadvisable to adopt any very active treatment. She was ordered blue pill with diuretics, under the use of which she experienced relief.

"Towards the end of April, she had an attack of spurious labour pains, which were relieved by an opiate. In this way, she went on until Thursday, May 7th, when she suddenly fell into a state of deep coma. On Friday I found the expulsive action of the uterus was commencing, and the os uteri being a little opened, I introduced a gum-elastic catheter through the membranes, and evacuated about three quarts of liquor amnii; and a considerable quantity afterwards drained away from the uterus. The uterine action continued, but the child was not expelled until 11 o'clock, a.m., of Saturday, the 9th. The state of deep stupor remained unaltered, and she died on Monday, the 11th.

"The body was examined 24 hours after death. The abdominal cavity contained about four gallons of yellow serum. The intestinal canal was sound; the uterus reduced to the size it might be expected to have 48 hours after delivery. The liver was remarkably small, and studded with tubercles, so as to look like the head of a cauliflower; being, in fact, a specimen of what is sometimes called the whiskey liver.* The iliac and femoral veins were most enormously enlarged."

In this case, the difficulty of detecting the presence of the child was extreme, indeed insuperable, although pregnancy was really advanced to seven months; and I had the assistance of one of the most experienced accoucheurs at that time in this city—one whose establishment of the correct theory of the spontaneous evolution of the fœtus in arm-presentations, in opposition to that of Denman, must transmit his name to future generations, as one of the most accurate observers who have ever adorned the ranks of midwifery; and several times while we were examining her, the woman declared, that she, at that moment, felt the active movements of the child; but by no mode of manipulation, external or internal, though made with great care, and frequently repeated, both by Dr. Douglas and myself, could the movements, or body of the fœtus be detected; and a like want of success attended the application of the stethoscope; for, in the most skilful hands, neither the fœtal heart-beat nor the uterine souffle could be recognised. The proximate cause of this difficulty seems obvious enough: the dropsy of the abdomen, which contained four gallons of serum, outside and around the uterus, within which was also the unusual amount of four quarts of liquor amnii.

No. 7.—Premature Discharge of the Liquor Amnii.

The lady whose case has been already related in No. 4, p. 18, was recently confined; and had again premature discharge of the waters, which continued to drain away from Thursday morning until the afternoon of Sunday, when labour was established, and she did well. On the former occasion the interval amounted to 68 days.

No. 8.—Inflammation, and morbid thickening of the Placental Membranes; their influence on the progress of labour.

Mrs. C., in her seventh pregnancy, and expecting her confinement about the end of February, or first week of March, was, on the 8th November, attacked with smart pain in the uterine region, accompanied by shivering, quick pulse, and tenderness, which, however, soon yielded to simple means, and after two or three days, she seemed quite convalescent.

On the 18th February I attended her in her confinement; and on examining the placenta and membranes, "*sicut meus est mos*," I observed that the latter felt unusually thick and firm, especially a patch about the dimensions of one's hand, which looked and felt like wash leather; and on examining more closely, I found, about the middle of this thickened portion, a sort of nucleus, in which the thickening and hardness assumed a more distinctly circumscribed circular figure, about an inch-and-half in diameter, and at its centre, nearly a quarter of an inch thick.

* See Baillie's Morbid Anatomy, Fasciculus V. pl. 2, p. 101.

The placenta presented nothing unusual in appearance or structure; the cord was natural, the child healthy and well formed; and except in the portion above described, the membranes were of their ordinary thin and transparent texture, and they had ruptured and discharged the liquor amnii, twelve hours before the accession of labour, which was short, and in every respect favourable; but when the morbid thickening of the membranes affects their whole extent they may offer a serious obstacle to the expulsive action of the uterus, greatly embarrass the diagnosis, and considerably delay the progress of the labour; of all which consequences, the following case affords a striking illustration:—

On Sunday, February 10, 1828, at nine o'clock, a.m., I was requested to see Mrs. D., some miles from town. She had been in labour for 24 hours, and when I arrived the uterine contractions were frequent and very active, and, as I was informed, had been equally so all night; but the labour was making no advance, though she had had children before, and the os uteri and external parts were in a state of complete dilatation.

On examination, I could only ascertain that the vagina was filled with a soft tumor of a doughy consistence, of the nature of which I could not, at first, satisfy myself, nor could I for some time feel the presenting part; but after waiting an hour, during which the pains were strong and forcing, but produced no advance of the uterine contents, I satisfied myself, by the introduction of my hand into the vagina, that the head was at the brim of the pelvis, and that the soft tumour in the vagina, which I at first thought might be the distended integuments of a hydrocephalic head, was really the unbroken membranes greatly thickened and much firmer than usual.

With considerable difficulty I succeeded in tearing them open; and, such was the force with which the uterus was acting, that the contained fluid was, on the instant, shot more than half way across the room, and a large loop of the funis descended before the head into the vagina. I at once expressed to the friends my apprehension, that the child would be still-born, except the labour terminated quickly, which it fortunately did, as the child was born in less than five minutes, quite inanimate at first, but by diligence in the application of ordinary means, I succeeded in resuscitating it. The placenta soon followed; and I left mother and child doing well.

Now, in this case, every part of the membranes was thickened, and to such a degree, that they had the consistence, and almost the strength, of wet doe-skin leather; for several hours, they had withstood the force of powerful uterine contractions, without giving way; and I found the greatest difficulty in tearing them open with my fingers.

Rigidity of the membranes is spoken of as a cause of slow labour, in systematic works on midwifery, as if it were a condition of very com-

mon occurrence; but, according to my experience, this is by no means the case; and in such a degree as to become an efficient obstacle to the effect of energetic uterine action, it is very rarely, indeed, met with; the delay, in those cases in which the membranes retain their integrity long after their descent into the vagina, and the complete dilatation of the os uteri, being, in the vast majority of instances, attributable to the weak action of the uterus, rather than to any excessive resistance from unusual strength in the membranes.

No. 9.—Remarkable form of Prolapse of the Pelvic Viscera.

About ten years ago, I was requested by an eminent surgeon to visit, with him, a lady of highly hysterical temperament, and otherwise in miserably delicate health; into all the particulars of which, I need not now enter, but confine myself to one fact connected with her case, which was very extraordinary, and without parallel within my observation or reading. It was stated to me that she was subject to prolapse of the rectum, to an unusual degree, and without any discoverable accompanying disease of the bowel; that the uterus descended at the same time; and that she could, at any time, by a voluntary effort, produce the displacement of both parts.

This I found to be the fact; and, while I stood by the bed-side, the lady, at my request, caused the descent to take place, while I carefully examined what occurred; and, to my astonishment, I found that the first step in the process was the descent of the uterus against the posterior wall of the vagina, which it carried before it into the rectum, into which it was received, until completely invaginated therein, and then expelled through the anus, surrounded, of course, by the displaced posterior wall of the vagina, and the anterior wall of the rectum.

I cannot say what became of the case afterwards, as I saw it only on the one occasion.

AMPUTATION OF A PORTION OF THE CERVIX UTERI, BY MEANS OF THE ECRASEUR.

By ALFRED H. MCCLINTOCK, M.D., M.R.I.A.
Master of the Lying-in Hospital, Rutland-square.

The attention of practical surgeons has of late been a good deal directed to the use of the Ecraseur, or Sarcotrite. The extent of its utility, and the place which it is entitled to hold among surgical instruments, are questions which experience alone can enable us to answer; and until they are answered, every solitary fact even, bearing in any way upon their solution, is of importance, and deserves to be recorded. I make no apology, therefore, for bringing before the notice of the profession

the history of a case in which the *écraseur* was employed for amputating a considerable portion of the neck of the womb.

M. M., aged 36, was admitted into the chronic ward of the Lying-in Hospital, on the 16th of last month. Her complexion was florid, and she had the appearance of sound health. She was at this time nursing her fourth child, of which she had been confined four months previously. About one month after her delivery, which was in every respect natural, she began to experience some uneasiness in her back, and to have a whitish mucous discharge, which latterly became rather profuse, and of a reddish, watery nature. This symptom induced her to seek advice. On examination I found the anterior lip of the uterus to be much enlarged, and the seat of a rather hard, rough fungus growth, involving nearly, but not quite, its entire extent. In front and at the sides a narrow segment of healthy cervix could be felt. The size of the tumor and lip from which it grew, altogether exceeded that of the largest walnut. Its colour was mottled red, or pink, and yellow, and in this respect closely resembled ulcerated cancer, as occasionally seen on the surface of the body, particularly the penis. When rudely manipulated, it yielded blood in small quantity. The posterior lip of the os was healthy and small, and the uterus itself was perfectly free and moveable. Examination of the tumor was not productive of any pain. I should not omit to mention that the vaginal discharge had the peculiar odour which belongs to cancerous disease. There was little room for doubt that this tumor was of a malignant kind; but in order to be further assured of this fact, I carefully removed a small portion of it with a scalpel, and gave it to Mr. Richardson for microscopic examination; and he reported it to be a fungus of the medullary kind.

The circumscribed extent of the disease, and the healthy condition of the patient, concurred to make me regard this as one of the few cases in which the complaint is met with at a sufficiently early period to justify an attempt at extirpation.

As a principal source of danger from the excision of the cervix uteri is hæmorrhage, I determined upon using the *écraseur*, should any operative proceeding be tried. Dr. Churchill and Dr. Hardy subsequently examined this patient, and coinciding in the view I had taken of her case, approved of the attempt being made to excise the diseased part. Accordingly, on the 24th of February, assisted by these gentlemen, and also by Mr. Collis—who obligingly lent his *écraseur* for the occasion.—Mr. Richardson, and Dr. George Montgomery, I proceeded to the operation.

The patient was placed on her left side, across the bed, with her legs flexed, and the thighs drawn up as much as possible towards the abdomen. After giving her a glass of wine, Dr. Montgomery administered the chloroform, and as soon as she was completely under its influence, I fixed

one blade of a vulsellum, anteriorly, on the healthy portion of the cervix, and at the angle of reflexion of the mucous membrane. The other blade was attached to the posterior part of the tumor, as high up as the state of the os would admit. With a little traction, carefully made in the direction of the axis of the pulvis, the tumor appeared beyond the vulva. The mobility of the uterus, and a relaxed condition of the vagina, very much facilitated this step of the operation. The chain of the *écraseur* was now placed, from behind, around the tumor, and as much above the grasp of the vulsellum as was practicable; and Mr. Collis, who held the handle of the instrument, began to tighten the chain, and continued to do so in a slow and gradual manner. Whether this would have caused any pain or not, it is, of course, impossible to know, as the patient was profoundly chloroformed. After the detachment of the tumor, the uterus, being then liberated, at once retired to its normal position in the pelvis. The vagina having been syringed with cold water, the patient was settled in bed. The entire quantity of blood lost did not amount, I should think, to four drachms, and was occasioned more by the preliminary manipulations than by the operation itself, so that the confident boast of M. Chassaignac—that by the *écraseur* a voluminous cervix might be completely excised without the loss of a drop of blood—was almost realised. On examination *per vaginam*, and of the excised portion of the cervix, we found that in front, the anterior lip had been removed so high, as even to include two or three lines of vagina; but that behind, where the chain and instrument could not be carried so far up, there remained a narrow selvedge of the fungus. The line of excision was consequently an oblique one, and extended from before, backwards, and slightly downwards; and the area of raw surface thus exposed was very considerable, probably greater than that of a crown-piece.

I thought it more prudent not to meddle with the uterus for a couple of days after the operation; but had the vagina well syringed with tepid water. When I did institute an examination, I discovered that in extent and in depth the wound was greater than I had supposed.

Up to the present time (March 10th), no unfavourable symptom whatsoever has shown itself. She has been perfectly free from uterine pain or tenderness; and the pulse (except on one day, when she had a slight attack of cynanche tonsillaris) has not ranged above the standard of health. On the fifth day she was up and dressed.

When I first examined the wound through the speculum, three days subsequently to the operation, it presented a uniform grey or ash colour; but at a later period it had a healthy granulating surface, which is rapidly diminishing in size.

I purposely abstain from pursuing the history of this case further than what relates to the operation or its immediate effects. I publish it merely

as an illustration of the use of the *écraseur* in amputation of the cervix uteri.—an application of the instrument, I may remark, of which its distinguished inventor gives only two examples; and one of them occurred in the practice of M. Depaul. Besides these, I am not aware of any other cases in which the instrument has been employed for the same purpose; but on this point I cannot speak with any degree of certainty.

So far as relates to the operation and its immediate effects, I see no reason whatever to regret its performance in the case just related.

Another, and quite a distinct question, is the probability of a permanent, or even a temporary cure, being effected through its means. It is obvious, however, that time alone can answer this, and its discussion I entirely keep out of view in the present communication.

A CASE OF AN UNUSUAL FORM OF EMPHYSEMA OF THE LUNG.

By JOHN K. BARTON, M.B.

A man 50 years of age was admitted into the hospital of the North Union Workhouse, on the 17th of December last, suffering from chronic bronchitis and emphysema, for which affections he had been treated in the Whitworth Hospital several times during the last two years; each time deriving such benefit from the treatment adopted as to be able to return to his situation, until he again got cold. Latterly, however, he found his strength very much reduced; and feeling unable any longer to hold his situation, which was that of waiter in a hotel, he sought admittance into the workhouse. His appearance was remarkable, the skin being pale, and the muscles universally loose and flabby; his lips and tip of the nose were bluish; at the same time his eyes were not suffused, nor did his face look congested. He complained of cough, difficulty of breathing, particularly at night, and constant coldness—he could not get warm; and his feet and legs got so cold at night as to prevent him sleeping. Upon stripping the chest its motions were seen to be very limited, inspiration being chiefly performed by the diaphragm; but the thorax was not rounded or prominent in any marked degree, as is usual in ordinary cases of chronic emphysema. Percussion gave a clear sound even over the cardiac region; loud bronchitic rales were audible in every part of the thorax; the heart's sounds were weak and almost inaudible from the rales in the overlapping lung. Counter-irritation to the chest, with stimulant and tonic medicines, gave relief at first; but when the frosty weather came on, his feet began to swell, his abdomen became distended with fluid, and by degrees the cellular tissue throughout the body became infiltrated. The urine was repeatedly examined, and was never found to contain albumen; but frequently deposited lithates upon cooling.

Alterative doses of mercury and diuretics were now used, but without any effect in reducing the dropsy, which greatly aggravated his dyspnoea.

His complaints of the cold were loud and unceasing. At last, when removed into a warmer ward than the one he had been lying in, and with additional covering, he said he could now sleep; but the dropsy continued to increase; his dyspnoea became very distressing at night; his pulse could no longer be felt at the wrist; and he died upon the 17th of February.

When the sternum was raised the lungs presented a very remarkable appearance; their edges met in the middle line so as entirely to conceal the pericardium; their surfaces, which were of a bluish colour, were dotted thickly over with numerous vesicles, varying from the size of a pin's head to that of a pea, white and shining, so as to give a glistening look to the lung. When the viscera were removed from the thorax, numerous bullae or cysts were seen projecting from the lateral and posterior surfaces of the lung; the apex of the right lung looked as if dilated with air, and from the base of the same lung there projected three cysts, nearly the size of a hen's egg each, quite circumscribed and separate from each other. The base, anterior edge, and external surface of the left lung were also studded with similar cysts. The air which these cysts contained could not be either forced from them under the adjacent pleura, or pressed out of them at all, without considerable force being used. When cut, they immediately collapsed, and when the wall was then carefully examined, partial divisions or septa were seen passing from one side to the other, giving a honey-comb appearance to the wall of the cyst. They did not look like mere elevations of the pleura, both from their being distinctly circumscribed, and from the purplish vascular appearance which the larger ones possessed. The bronchi were traced of their natural calibre throughout the lung, but not distinctly to any of the cysts. Their mucous lining was of a deep red colour. The heart was healthy both in its valves and structure; the right side, if dilated at all, was so to a very slight extent. A great deposit of fibrine existed beneath the capsule of the liver. The kidneys were healthy. In considering this case the first question which arises is, what was the cause of the dropsy which existed so persistently during the last month of life, and in the end was the cause of death? That it did not exist in the kidneys was proved by the state of the urine during life, and the examination of the kidneys after death. The heart cannot be assigned as opposing any obstruction to the circulation through itself, as its cavities were not dilated, and its valves were perfect. We must look to the lungs, then, as the cause of the obstructed circulation; and when we reflect upon the pressure which these dilated cysts must have exercised upon the capillary vessels which surrounded them, and that a very small part of the lung remained

in which any oxygenation of the blood can be supposed to have gone on, we will be prepared for the three-fold symptoms which existed in this case, viz:—1st, obstruction of the general venous system, resulting in dropsy; 2nd, a feeble, weak, and failing pulse, arising from the small amount of blood which reached the left side of the heart; and 3rd, the constant complaint of cold, resulting from the excessively deficient oxygenation of the blood. In the production of the dropsy, however, I think we must admit that the watery state in which the blood was, had a share, causing effusion into the cellular tissue to occur rapidly when any obstruction occurred in the course of the circulation.

Comparing the symptoms of this case with one of ordinary vesicular emphysema of the lung, the following appear to be the chief differences. The shape of the chest was not as rounded or barrel-shaped as in ordinary cases which have advanced towards a fatal termination; and yet the symptoms of obstruction to the return of the venous blood, and the deficient supply to the left ventricle, were much greater. And in their pathology there is this remarkable difference, that in the present case death was produced without the right side of the heart having become dilated; while in the ordinary form the right cavities have generally undergone great dilatation before the final symptoms of dropsy come on. The only way apparently for accounting for this is that these cysts were produced much more rapidly than the usual vesicular emphysema is; and that, therefore, the heart had not time to undergo a process of dilatation before the obstruction in the lungs proved fatal.

Cruveilhier, in describing* a *Cystic dilatation of the air vesicles*, which seems to correspond very closely to the appearances found in this case, makes the following observations: "An important point in the descriptive anatomy of these air-containing cysts of the lungs is their mode of communication with the bronchi. Generally, compression of the cysts causes the air to pass, with more or less difficulty, into the bronchial tube which leads to it; but at other times the cysts resist pressure to such a degree as to appear completely isolated from the neighbouring tubes. This last condition, which has been frequently observed, seems favourable to the opinion of those who reject the vesicular emphysema of Laënnec, and admit no other form of emphysema than that by rupture or intra-lobular. Without doubt upon this hypothesis we can explain the encystment of the air, by supposing surrounding adhesion; but this air, once encysted, how is it renewed? It cannot remain as it is without being absorbed; for air infiltrated into the cellular tissue, is absorbed with the greatest facility. The renewing, then, of the air in these cysts is a necessary condition for

their existence; but the renewing of the air can only be explained by the cysts having their origin in the dilatation of the air vesicles."

Dr. Carswell gives a plate of this disease in his pathological anatomy, as one of the unusual forms of emphysema of the lungs.

AMERICAN SPLINT, FOR FRACTURE OF THE FEMUR.

By P. B. MANSFIELD,
Assistant-Surgeon, R.N.

To the Editor of the Dublin Hospital Gazette.

SIR,—At the hospital, first established by the Panama Railway Company, in Colon, Central America, Dr. ROGERS, the senior surgeon, called my attention to a most admirable form of Splint, newly brought into practice, but extensively used throughout the United States, in cases of fracture of the femur.

A long splint, something narrower than Desault's, well padded, and fitted exactly as a crutch, extends from the axilla five or six inches below the external malleolus. It is confined in the usual way, to the body, by a very wide duck belt.

On the inner side, a shorter splint, extends from the perineum, where it fits most exactly and easily, downwards, to the same distance below the foot as the outer splint.

These splints are connected by three thin iron bridges, capable of being bent, so as to allow of the splints being approximated, when necessary, or of being drawn apart, to give room for opening the Scultetus bandage, in cases of compound fracture. They also (a point of great importance) form an excellent cradle, and protect the leg from pressure of the bed-clothes, as well as support it.

At the ends, the splints are connected permanently by means of "a crosspiece," which keeps them wide enough apart to prevent pressure on either ankle, and to allow space enough for padding, of which there is an ample supply inside each splint.

A wide strap of adhesive plaster (spread on strong duck) is applied to the leg (before the bandage), commencing at the knee-joint, on either side; it is continued downwards, and leaving a loop of two or three inches under the sole, is taken up on the other side, to the point corresponding to that from which it started. This loop, when the splint is adjusted, should reach to within three or four inches of the "crosspiece," around which, and through the loop, is passed a piece of bandage; this being knotted, draws the "loop" as near the "crosspiece," as possible.

A piece of wood to form a handle, is now placed between the piece of bandage and the "crosspiece," which an assistant, twisting, and using traction at the same time, causes the bandage to shorten so much, that a gentle and steady extension is made

* Anatomie Pathologique, tome deuxieme, p. 901.

while the surgeon coapts the fractured parts with great facility, and but little pain to the patient.

The handle can be easily prevented from untwisting, by simply tying it down on the "cross-piece;" and even if, by the stretching of the plaister or bandage, the leg should shorten a little, a few *twists* of the handle will set all to rights again, without any trouble. I might suggest that a plain leather *strap* and *buckle*, passed round the "loop" and "crosspiece," with a good number of holes, placed near each other, might be substituted for the handle and bandage.

Being, I may say, comparatively unknown at home, its novelty, as well as utility, and means of comfort to the patient, may make it a not unsuitable subject of a note for your valuable journal. The points in its favour are, that it makes "extension" and "counter-extension" easy, certain, and attended with very little pain, whilst *coaptation* can be nicely performed; all this is accomplished almost *at once* and effectually, and frequent disturbance is rendered unnecessary. Lastly, extension is made from the *entire* leg, instead of the *instep*; the "crosspiece" protects *both* ankles from pressure; and the axilla, becoming a *second* fulcrum, relieves the perinæum to a very great extent.

I have seen five cases turn out very creditably; and have no doubt that if introduced into our own hospitals, in a short time, having undergone, probably, many little improvements, it would become a favourite mode of treatment.

PIERCE B. MANSFIELD, B.A., M.R.C.S., Ed.,
Assistant-Surgeon, H.M.S. Orion.

December 1st, 1856.

DR. THOMAS HAYDEN ON THE MORE RECENT IMPROVEMENTS IN ANATOMY AND PHYSIOLOGY.

[*The following remarks on the more recent discoveries in Anatomy and Physiology, which were the subject of a Lecture delivered by DR. HAYDEN in the early part of the present session, have for some time been unavoidably held over.*]

Living beings are offered to our notice under two aspects—as presenting forms and performing functions. The department of science which treats of them in the former relation is called "Morphology," that in the latter "Physiology." These two grand divisions of biology are themselves resolvable—Morphology into "histology," which treats of the elementary structure of tissues; "anatomy," of their perfect structure and mutual relation; and "palæontology," which professes to infer form and function from the fossil remains contained in the earth's crust. Physiology, likewise, into "physico-chemical," of which the province is to investigate the laws governing the physical actions of organised bodies; and

"psychology," those relating to mental operations. Living beings may be either dormant or active. If dormant, they are capable of being roused into action by certain agencies, viz., heat, light, moisture, and electricity, which are hence called "vital stimuli;" and in this state they are distinguishable from *not*-living beings by their tendency to pass through a cyclical succession of changes of form and composition, whilst the latter are either stationary or undergoing disintegration. Again, a living being is remarkable in that it never presents a regular geometrical figure or plane surface, like a crystal; and further, it invariably exhibits a definite structure. No living being consists chemically of less than three elements, and probably four, viz., carbon, hydrogen, oxygen, and nitrogen, in the proportion in which they form, protein; whilst inorganic bodies present the most varied chemical constitution, from a simple element to the most complex atomic arrangement. The allied forms of animal and vegetable organization are distinguishable rather by functional than by structural peculiarities; thus, the lowest plant, as well as the highest, possesses the remarkable power of *feeding* upon the simple elements, oxygen, hydrogen, nitrogen, and carbon, detaching them from their binary combination in air and water, and uniting them into the ternary and quaternary compounds of chlorophyl, albumen, and starch; whilst animals derive their nutritive supply exclusively from organic substances, and thus are dependent, directly or indirectly, upon the vegetable kingdom. Plants appropriate their aliment by imbibition through the external surface of their bodies; animals either possess or extemporise a digestive cavity, in which the primary stages of alimentation are performed. Plants are either wholly incapable of spontaneous motion, or, in the few examples in which they possess this faculty in their embryo condition, it is accomplished by the action of "cilia," and has reference entirely to their dispersion; animals, on the contrary, in their simplest known forms, effect change of place by motions indisputably voluntary. The boundary line between the animal and vegetable kingdom is not, however, strictly defined; rather it is transgressed at certain points, in such a way that the adjacent territories are, as it were, dovetailed into one another. The "*Acephalocystis endogena*," or pill-box hydatid, has neither a permanent nor temporary stomach, and obtains its food by superficial imbibition, like a plant. Amongst vegetables, the "*Sarracenias*" possess peculiar organs, called "pitchers," into which insects are attracted by the presence of a sweet gummy secretion, and their exit barred by long hairs, growing from the inner surface; within these receptacles their bodies are dissolved, and appropriated by the vegetable tissues; here we have something exceedingly like a digestive cavity, and digestion of solid and organic aliment. Thus, then, it may be said—

so closely allied are the two great organic kingdoms of nature, that, as represented by their lowest forms, they might be readily confounded with each other, and so intimately related, that even when best defined, they still touch by their angles, but from these points of mutual contact they diverge almost indefinitely. All animals agree in the possession of three essential properties: *absorption*, *metamorphosis*, and *irritability*: the first, physical, the second chemical, and the third vital; and their chief morphological differences depend upon the multiplication of organs in subjection to these properties. This law, of the physiological division of labour, is universal throughout the animal kingdom, but of the organs destined to execute it, there is a difference in *kind*, for the several classes of a sub-kingdom, and in *degree*, for the orders of a class; and both increase with the distance between the extremes in each class and order. The morphological differences just adverted to, as having direct reference to function, constitute "typical variation," and form the basis for the natural division of the animal creation into the five grand "types"—"Protozoa," "Coelenterata," "Mollusca," "Annulosa," and "Vertebrata."*

Schleiden and Schwann taught that all organised structures, both animal and vegetable, originate from cells, as their primary or embryonic form; that these cells are anatomically and physiologically independent; that they are the *causes* or *centres* of organization; and that all organs and organisms result from their coalescence; that a typical cell consists of cell-wall, cell-contents, and cytoblast or nucleus; that new cells were formed by the development of new cytoblasts in the surrounding cytoblastema; and that the cell-wall was secreted from the surface of the cytoblast, and subsequently separated from it by the accumulating liquid cell-contents. In this theory of cell-generation a very important element, as far at least as regards vegetable anatomy, was entirely overlooked, the "primordial utricle" of Von Mohl; this is a nitrogenous membrane, lying within, and in close contact with, the cellulose cavity, or so called cell-wall of Schleiden and Schwann. These authors assumed that the cytoblast was the essential or formative element of the cell; but the observations of Mr. Henfrey have shown that no cytoblast exists in the germinating parts of young ferns; and many similar examples amongst animals and vegetables may be adduced. Modern research has satisfactorily proved that the "primordial utricle" is, in cell-growth, what Schleiden and Schwann believed the "cytoblast" to be—the essentially formative organ of the cell; for in its substance nuclei have been observed in process of development, and new cells to result from its division; and further, the observations of Wenham on "*anachais alsinastrium*," those of Mr. Davy on

the briony plant, and Mr. Rainey on the development of the tentacles of "*cysticercus*," have clearly demonstrated, that at no period of the development of these structures, are cell-formation and cell-growth, as commonly understood, to be observed. The primary basis of all organized structures consists of two elements:—a clear homogeneous matrix, called "periplast" by Huxley, and a number of minute bodies dispersed through this, the "endoplasts" of the same writer. The latter, in their simplest form, are solid spherules, composed of a structureless material named "protoplasm," destitute of a limiting membrane, and generally containing in their centre an aggregation of granules constituting a *nucleus*. The simple structure now described, represents the earliest stage of organization with which we are acquainted, and through it all organized tissues, no matter how highly developed subsequently, must pass in their upward or *histogenic*, and in all probability also, in their downward or *histolytic* course. Beyond this primary stage, however, a number of vegetable structures never proceed; such are the "protophyta," or confervoid algæ. If a higher grade is to be attained, the "endoplastic" bodies are converted into cells, by a process of differentiation of the originally simple spherule into cell-wall, "primordial utricle," cell-contents, and nucleus; the agency by which this is accomplished is involved in the mystery of life, and is indifferently named "vital force," "metabolic force," or "*vis essentialis*."

With the formation of cells, what might be called the second stage of organization is attained, and is represented in a persistent form by the cellular tissues of animals and vegetables. All further progress towards the higher grades of development is effected by the modification of cells; and the study of this, in its various ramifications, constitutes the special department of histology.

Cells, then, are not the *centres*, nor even the *instruments* of organization; they only constitute one stage of the process, and appear to possess no special influence beyond the limits of that stage. Life is, in all probability, *molecular* not *cellular*, and cells are the exponents of vital phenomena only in the proportion of their constituent granules.

The process of growth involves two distinct operations—*accretion* and *differentiation*. In that stage of development which I have ventured to designate "the first," and of which the protophyta amongst plants, and the "protozoa" amongst animals, afford striking examples, growth appears to consist in a simple accretion or coalescence of particles, without further differentiation of parts than a slight difference of consistence between the "periplast" and the "endoplasts;" but in all stages above this, there is both a morphological and a chemical differentiation, the former consisting in vacuolation and fibrillation, the latter in conversion and deposit.

* Huxley

One of the humblest forms of vegetable organism is the "*palmogloea macrococca*," found to consist of a simple mass of nitrogenous substance, named "protoplasm," containing a nucleus and some chlorophyl granules, and embedded in a viscid homogeneous matrix. Multiplication is effected by spontaneous division of the minute body into two portions, which are next separated by the ingrowth of the surrounding matrix, each segment becoming a perfect representative of the original. These changes may be seen actually taking place by microscopical examination.—Parallel examples from the animal kingdom are furnished by the *amæba* and *actinophrys*, which are simple accretions of a substance called "sarcode" by Dujardin, without investing membrane, or internal structure. In the interior may be observed one or two vacant spaces, the walls of which are endowed with a contractile property, and are seen in the living animal to contract and dilate alternately, at a fixed rate, which I have determined in the "vorticella," a closely allied organism, to be five times in a minute. The "*amæba*" assumes a variety of forms, and is hence sometimes named "proteus;" it advances by projecting a portion of its body in the form of an elongated process, which it fixes to the neighbouring surface, and by this means drags the remainder along at a sluggish pace; if in its course it happen to encounter a suitable particle of aliment, it forces this through the soft tissues of its body into the interior, where its nutritive elements are absorbed, and whence the refuse matter is expelled by a similar process. The *actinophrys* differs from the *amæba* only in preserving a definite form, and possessing a number of long prehensile organs, called "pseudopodia," by means of which it grasps and engulphs its prey. Thus, the only distinctive character between these lowly creatures and the humble *Palmogloea*, consists in the possession by them of a contractile vesicle, and of the faculty of progression; they both fall short of the degree of development attained by an ordinary cell, form the starting points respectively of the animal and vegetable creation, and are therefore appropriately named—the one, *protozoa*, or primitive animals; the other, *protophyta*, or primitive plants.

As an evidence of the importance of the study of "typical organization" as tending to facilitate the labours of the naturalist, and of the great progress now being made in the elucidation of this subject, may be mentioned the relations recently proved to subsist between the tænioid and cystoid organisms. Up to a very recent period these two families of entozoa were regarded as perfectly distinct; but by the labours of Von Siebold and Van Beneden, their identity has been placed beyond the possibility of cavil. The distinguished professor of zoology in the University of Louvain, has divided the development of *Tænia* into four stages:—those of the "embryo," "scolex," "strobila," and "proglottis." The "embryo" is a vesicle

with hooklets attached to one portion of its surface. The "scolex," in addition, develops a head, with its appendages of hooklets and suckers. The "strobila" is the perfect tapeworm; and the "proglottis," one of its somites or segments detached and distended with young. The detachment of proglottides takes place from the posterior extremity of the body, whilst at the same time other segments are formed or inserted between the head and neck of the animal; there is reason to believe, however, that the "scolex" is the formative part, and herein lies an explanation of the circumstance known to all practical physicians, that without the expulsion of the head of the tapeworm, a cure from that parasite cannot be affirmed. The identity of the cystic and cystoid organisms has been proved experimentally by Leuckhart, Van Beneden, and Von Siebold. Puppies have been fed with "*cysticercus pisiformis*," and in the course of a few weeks, their intestines were found nearly full of *Tænia serrata*; on the other hand, a rabbit was fed with the ripe proglottides of *Tænia serrata*, and a week afterwards, its liver was studded with minute cysts containing ascaroid formations. In another rabbit similarly treated, these were found in the scolex stage, in the peritoneal cavity. The liver of white mice, fed with the proglottides of "*Tænia crassicolis*," was found infested with "*cysticercus fasciolaris*," and the muscles of pigs fed on *Tænia solium*, presented the "*cysticercus cellulosus*," constituting the condition commonly known as that of "measley pork." A lamb fed on "*Tænia serrata*," manifests within a fortnight symptoms of the disease called "staggers," and a week or two subsequently its brain is the seat of "*cœnurus cerebri*."

It is well known that the intestinal canal of carnivorous vertebrata, such as man, the dog, the cat, the lion, is the sole habitat of *Tænia*; whilst cystoid entozoa may infest the muscles, the eye, the liver, the brain, and other parts of vertebrate animals, both carnivorous and herbivorous; and further, that certain species hitherto regarded as distinct in their origin and organization, are peculiar to certain parts of some of these animals, as the "*cysticercus cellulosus*" to the intermuscular cellular tissue of man and the pig, and "*cœnurus cerebri*," to the brains of young sheep. With the facts just enumerated before us, we can have no difficulty in comprehending the cause which determines the development of the embryo cysticercus into the *Tænia*, in the body of the dog; and that of the "proglottis" of *Tænia* into cysticercus or *cœnurus*, in the rabbit or lamb; it lies in the law of modification of species dependent upon locality.

The three great branches of biology—development, structure, and function—were probably studied, at least primarily, in inverse order: function excited the wonder of man; from this arose curiosity to ascertain structure; and then, again, to

determine the process by which this structure came to be.

The different parts of living beings are mutually related. This correlation is of two kinds—*physiological* and *morphological*. The physiological correlation implies a typical conformation of organs, leaving a broad margin on either side, within the limits of which it is possible to deviate, without deranging their harmonious action, or materially altering the result. Thus, the multicuspid teeth and quadrilocular stomach of a ruminant, are physiologically correlated, the common end being alimentation. Yet, a deviation from the typical number or conformation of the teeth, or even their total absence, will not seriously modify the nutritive process. Again, although the lanian teeth of the tiger would enable us to predicate of that animal the possession of a simple stomach, were we to reason from the same premises to a similar conclusion in the case of the dog, whose teeth are no less efficient instruments of laceration, we should fall into a serious error, for the digestive tube of this animal, as will be observed, is by no means a simple organ.

The laws which govern *morphological* correlation are, on the contrary, simply empirical. We know from experience that certain organs and a definite conformation of them, co-exist in the same animal; but as to *why* they do so, morphology taken exclusively teaches nothing; physiology, however, supplies this deficiency, and explains the *why* by reasoning out the common end. Thus, then, these two branches of natural science interpret each other, and it is impossible to study either efficiently, and in the full measure of its attractiveness, without the aid of the other.

PATHOLOGICAL SOCIETY OF DUBLIN.

A meeting of the Pathological Society was held on Saturday, January 31st,

Dr. LAW, V.P., in the Chair.

Professor BANKS presented the morbid appearances in a case of

Encephaloid Cancer of the Ovaries and Kidneys, in a patient aged 37, who was admitted into the Whitworth Hospital on the 6th of January. Ten months previously she was delivered of her tenth child. Her confinement was favourable, and her health continued good until the end of December, when she perceived a swelling of the abdomen, on the left side; from this time her health gradually became impaired, her appetite and her strength failed, and the tumor, which at first did not cause her the slightest inconvenience, became the seat of pain. On being received into the hospital, she presented very much the appearance of a person labouring under organic disease of the liver. There was a slight icteroid hue of the skin; the abdomen was large and flaccid, and contained a considerable

quantity of fluid; a tumor was felt at the left side, which extended from the left iliac region to the mesial line; it was moveable, and painful on pressure. The urine was scanty and rather high-coloured, but otherwise normal.

From the time of her admission into hospital the progress of the case was rapid. The legs became oedematous, and also the left arm; the pulse small and rapid; and the strength was obviously failing. Her nights were restless. The stomach, which for some time was irritable, soon rejected almost everything. Diarrhoea finally set in, and death took place on the 30th; the twenty-fourth day of her residence in the hospital.

The examination after death revealed the following morbid appearances:—The abdomen contained about a gallon of straw-coloured fluid, not unlike olive oil. On the left side was a large ovarian tumor, presenting a good example of encephaloid cancer. Its surface was tolerably smooth in general, but here and there small nodules existed. The tumor was marbled, and of a brown colour. On being cut into, the structure was found to resemble brain in appearance and consistence. In the centre it was broken down, and the cavity contained some dark-coloured fluid. The right ovary, which was not one-sixth of the size of the left, was also the seat of cancerous degeneration. The kidneys also presented an example of encephaloid cancer; the organs being completely changed into a diseased mass, each weighing one pound.

Dr. Banks observed, that this case was of interest, from its being even more rapid in its progress than cases of ovarian cancer generally are, and from both ovaries being invaded by the disease. The cancerous disease of the kidneys, moreover, occurred at an earlier age in this instance than usual; and it is also worthy of notice, that the urine was normal, notwithstanding that the kidneys appeared to have lost every trace of their original structure. In connexion with the last point, Dr. Banks referred to a case reported in the transactions of the Pathological Society of London, in which the urine was natural, although the kidneys were converted into cancerous masses.

Sir PHILIP CRAMPTON detailed the history of a case of

Fungous Growth from the Bursa Patella.

The disease termed "housemaid's knee" occurred in a police officer, being the consequence of a fall from his horse; he, however, recovered the effects of the injury, and during a period of sixteen years, continued a very active life. He did not pay the slightest attention to his knee, which never caused him any pain until about two months ago, when he became ill, was attacked with fever, and violent inflammation set in, which ended in suppuration of the tumor; and after a short time, a large bleeding fungus shot out from its surface. Amputation of the leg was proposed

to him by a gentleman who attended him in the country; but he declined the operation, and came to Dublin for further advice. Sir Philip Crampton, after a careful examination of the tumor, determined to excise it with the knife, the only case of this kind—namely, of a fungous excrescence springing from the suppurating surface of the bursa in “housemaid’s knee”—that had ever come under his notice during his extensive practice, and which he had attended along with the late Mr. Abraham Colles, having been treated in this manner with the greatest success: and the individual was seen, upwards of 20 years afterwards, by Sir Philip Crampton. The appearance which this fungus presented was calculated, even from the first, to be mistaken by an inexperienced surgeon for a malignant growth. It presented exactly the appearance of a fungus hæmatodes, and bled profusely upon the slightest touch. The distinguishing mark, however, was a ring of healthy granulations, which surrounded the tumor close to the skin, and which, together with a portion of healthy integument, were allowed to remain on removing the fungus. When performing the operation, Sir Philip Crampton stated that he forced out with his fingers large pieces of the growth, which appeared to be of cellular structure; and that, had he seen this circumstance in the first instance, he would have been tempted to have concurred in the opinion of the medical gentleman who had seen the case in the country, which was, that the limb should have been amputated above the knee. Although this growth, at first sight, resembles so closely one of malignant formation, yet an accurate and careful examination will generally enable the surgeon to determine its character satisfactorily. In this case the operation met with the greatest success, and shortly afterwards the gentleman rode home to his family in the country.

Aneurism of the Abdominal Aorta.

Mr. G. PORTER exhibited a specimen of abdominal aneurism, which occurred in a female who dropped dead as she was walking through Dame-street. Dr. Porter, who removed the tumour, found it impossible to obtain any thing like an accurate history of her case; a few circumstances in point were, however, ascertained. She was a prostitute, thirty years of age, and for the last three or four years had been continually drinking. About twelve months ago she had taken a course of mercury; and up to July last had enjoyed very good health. About this time, however, she began to suffer much from a pain in the abdomen, which she ascribed to flatulency; further than the annoyance which it occasioned her, she did not pay it much attention; and a few nights ago, when she was walking through Dame-street, her knees gave way under her, and she fell to the ground.

On opening the abdomen, and removing the intestines, a large aneurismal sac was found en-

gaging the abdominal aorta, about half-an-inch below where the coliac axis is given off. It had burst at its posterior and inferior part; and, contained in the peritoneum behind it, was a large quantity of coagulated blood. There were two circumstances of great interest connected with this case. The first was the age of the woman—she was only thirty years of age; and the second was, that although the whole of the aorta was carefully examined, there did not appear to be the slightest trace of atheromatous deposit upon its coats, which were remarkably soft and flabby.

SURGICAL SOCIETY OF IRELAND.

A meeting of the Surgical Society was held on Saturday evening, March 7th,

The PRESIDENT OF THE COLLEGE in the Chair.

Compound and Comminuted Fracture of the Hand and Forearm—Primary Amputation.

Dr. FLEMING exhibited a portion of the left upper extremity, which he had removed a week since, in the Richmond Hospital, from a man aged about 30 years. He regretted the specimen was not in a more recent state, but even yet, many points of practical value were deducible from it. The man had been cleaning the wheel of a portion of the machinery in a distillery, when, by some accidental circumstance, his hand and forearm were dragged in and caught between the cogs. Dr. Fleming directed attention to the crushes of the bones of the hand, and to the fractures of the radius and ulna, and especially to the condition of the muscles, fasciæ, and skin, and the necessity for caution in estimating the amount of injury done to the soft parts from external appearance.

As is usual in such cases, the man was brought into hospital in a state of collapse. He had not lost much blood; neither was there much hæmorrhage when first visited by Dr. Fleming, about an hour after the injury. No second opinion could be entertained as to the necessity for amputation of the injured limb; and reaction having been fully restored, the operation was performed about four hours after the occurrence of the accident.

The site of the operation, and the use of chloroform, formed two important points for deliberation. With some persuasion the man submitted to the removal of the limb below the elbow. Operation by the circular incision was decided upon as being the most favourable, the very thin skin, the small amount of subcutaneous fat, and the large muscular development, particularly favouring its adoption.

Dr. Fleming directed attention to the great caution required, during the use of chloroform in states of collapse, whether from injury or otherwise. Some deviations from the ordinary course of its effects was to be expected: the mind was often wakeful, and yet sensation was blunted, and he

questioned very much the propriety of pushing too far the full anæsthetic effects, as far at least as cerebral symptoms were concerned. He instanced cases of strangulated hernia, where collapse was often extreme, and where chloroform was most successful in staying sensation, although the intellect was perfectly clear. In the case under consideration, most alarming symptoms suddenly manifested themselves, but owing to the great caution used, they were quickly combatted by ammonia, &c. Dr. Fleming concluded by alluding to the value of the use of opium in large doses, repeated at short intervals, after serious operations, and accidents occurring in individuals in full health; and considered this medicine, combined as the case may require with antimonials or with aperients, as a most excellent means of reconciling the system to the sudden shock which it has sustained, and of preventing those contingencies which too often supervene, and perplex the surgeon; as for instance, irritative fever, hæmorrhage, and tetanus.

Dr. Power detailed the particulars of a case of
Necrosis of the Condyle of the Lower Jaw.

This case will appear at length in the reports of the Pathological Society.

ABSTRACT OF THE PROCEEDINGS OF THE BELFAST CLINICAL AND PATHOLOGICAL SOCIETY.

SESSION 1856-7.

Fourteenth Meeting, Saturday, January 31st.

The President, Dr. M'GEE, in the Chair.

Surgeon HARKIN gave the following history of a

Case of Punctured Wound of the Thorax,

presenting features of great interest in a medico-legal point of view.

J. S., æt. 20, was knocked down in a quarrel; when he rose he found that he had been stabbed in the chest. His wounds were dressed, and he was then removed to the General Hospital. His adversary was arrested, and committed to jail; and my connexion with the case arose by the solicitor for the defence requesting me to watch the progress of the case in the interest of the prisoner. On more careful examination, it was found, that out of four punctured wounds of the left side of the chest, at least three were penetrating. In hospital the patient passed through the inflammatory stage very safely; and although there was evidence of effusion, it was rapidly disappearing. The external wounds had closed; the patient was removed into the convalescent ward, and allowed to sit up at the fire and walk about the ward. The beginning of another month brought with it a change in the medical attendant. The new medical officer finding some pleuritic pain persistent, applied a blister over the seat of pain. This

application relieved the pain, but opened the wounds anew. Dysentery was then epidemic, and the patient partook of a bowl of soup along with some dysenteric patients in their convalescent ward. The immediate result was an attack of acute dysentery, under which the patient died in about 12 days. The question then arose—what was the cause of death? Was it the result of the injury to the chest and thoracic viscera, or of the dysentery?—and if of the dysentery, was that disease the natural consequence of the wounds—a symptom of hectic fever, in fact—or was the dysentery caught in the convalescent ward? If the former, then the man was murdered; if the latter, he died of disease caught in the hospital—a conclusion widely different, and of vital importance to the man who inflicted the wounds. To remove these doubts a *post mortem* examination was held in presence of the medical men connected with the hospital, and others concerned for the next of kin. The following is from my notes taken on the occasion:—The body was very much emaciated. There were found on the left side of the chest the marks of four punctured wounds—one completely cicatrized, two partially healed, one quite patent. On removing the sternum and portions of the ribs, we found a perforation between the third and fourth ribs corresponding with the cicatrized wound; further down, a second opening, between the seventh and eighth ribs, corresponding with the open wound; and again, opposite one of the partially healed wounds, a third perforation, complicated with caries of the ribs. The knife, in this instance, had pierced a fold of the diaphragm, without entering the cavity of the abdomen. The left side of the chest contained about eight ounces of purulent matter; the pleura of that side was thickened, and covered with coagulable lymph, partially organized, and red. That portion of the pleura lining the left side of the sternum had been removed by ulceration, and a layer of thick pus deposited in its place. The left lung was, almost to its whole extent, solidified; near its apex we found a scar, as if where the knife had entered, but it was healed up. The inferior part of one of the lobes presented an open wound, looking towards the ribs, and evidently much contracted in size, the result of the wound in that part of the chest. There was not any evidence of pneumonia, the solidification having been the evident effect of the effusion. The right lung was quite sound; the right pleura contained scarcely any fluid. The pericardium contained about two ounces of fluid; no adhesion, or other indication of disease. The heart itself perfectly healthy. The bronchial tubes were rather congested, but the redness, &c., was cadaveric. On opening the abdominal cavity, the omentum wanted its usual supply of fat; the liver and spleen were healthy, the latter slightly adherent to the diaphragm. No renal disease; the stomach and abdomen very healthy; they contained a little yellowish fluid. The small intes-

tine, for about 18 inches above the cæcum, presented every symptom of acute inflammation of the mucous membrane. The large intestine was distended through its whole extent, and on being slit up, exhibited the appearance of extensive ulceration of the mucous membrane, most highly intensified in the cæcum, and gradually declining, yet still well marked to within two inches of the anus. The lining membrane was completely honey-combed, and the whole looked much more like tripe than human intestine. The mucous membrane between the ulcers was covered with layers of lymph, and the glands much enlarged; but no complete perforation existed. No effusion into the peritoneum, nor any adhesion of the intestines. As there had not been any sign of head symptoms, the brain was not examined. The conclusion I came to was, that the symptoms during life, as well as the pathological appearances, fully justified a favourable prognosis up to a certain point; that the reparatory process was steadily progressing, up to the period of the patient's visit to the dysentery ward; and that he then contracted the disease of which he subsequently died. At the Coroner's inquest I gave evidence to this effect. The medical men connected with the hospital concurred with me in every particular; one medical man, however, who did not believe in the infectious nature of epidemic dysentery, delivered a contrary opinion; but the weight of medical testimony having been on one side, the jury returned a verdict of "death from natural causes."

DR. C. PURDON read the following

Case of Poisoned Wound, complicated with Delirium Tremens.

A. B., æt. 33 years, stout and able-bodied, of a healthy constitution, was attacked with delirium tremens, after above three weeks' drinking. He became slightly jaundiced, and had vomiting and hiccup. These latter complications were removed by appropriate treatment; and as he was progressing towards recovery, he suddenly jumped out of bed, and before he could be prevented, plunged a dagger-shaped knife, about six inches long, into his abdomen, about one inch below the ensiform cartilage: this he did *three* times, driving it up to the hilt. Very little blood issued from the wounds. The knife *had been used for cutting tobacco*. When visited immediately after, he was lying on his back, breathing calmly; pulse, 84, and good. The wounds were dressed, and he was kept under the influence of opium, which soon produced sleep; and he awoke quite recovered from the delirium tremens. The opium was continued; and for the next six days there was no tenderness, on pressure, over the wounds, nor any hardness in the hepatic region. His pulse varied from 76 to 80, and was steady. He slept well each night. The wounds cicatrised; and he was so far recovered as to be able to remain down stairs for some hours. In two days after he became

worse; he ceased to sleep, and the opium was resumed, and continued in large doses, without any effect for 36 hours; at the expiration of this time he slept for a little. Pulse 84; no nausea or vomiting; tongue creamy and moist; no tenderness; no hardness over the liver. He now became suddenly collapsed; pulse barely perceptible and fluttering, about 180. After much trouble he was restored from this state, and the pulse fell to 108. Violent hiccup supervened, which was removed, at first, by warm applications; but returned again and again, for 36 hours, and was only checked by a horse-shoe-shaped blister, applied over the insertion of the diaphragm. The heart at this time was beating very irregularly, and would sometimes stop. The treatment consisted in the exhibition of opium and mercury; the latter by inunction, as well as internally. The system resisted its influence very much. After a short time, the patient's state seemed to improve; the tongue became clean; and the opium alone was now continued. The heart's action still continued irregular; and he had at this time two severe attacks of colic, with slight tympanitis; these were easily relieved at first; but after one of these seizures, for which his brother had given him some ether and laudanum, the vomiting recurred, he again became jaundiced, his feet oedematous, and the hiccup also returned at intervals, though he had been free from it for seven days. It now continued for 24 hours, when he suddenly felt something give way in his back, at the right side; He obtained immediate relief from the hiccup, and the heart's action became regular. *The next day he passed a considerable quantity of matter from the bowels.* The oedema became less, and the jaundice almost disappeared. Some hardness could now, however, be felt over the liver, and it began to enlarge, and continued to increase, at its left side particularly. Leeches were applied, followed by a blister. Shortly after this he had a rigor; the oedema again increased, and he suffered under frequent attacks of hectic fever. He became sleepless, and frequently delirious; there was a good deal of nervous agitation, with picking of the bed-clothes. The muscles at the back of the neck became rigid and contracted. There were frequent attacks of rigor; and a crepitus was heard over the right lung, with dulness on percussion. The supervention of these symptoms was attributed to a poisoning of the system—pyæmia. On the 12th of November, after an attack of delirium, he became agitated in a peculiar manner, like one stuttering, and afterwards was not able to pronounce the letter "I," and instead of saying "I want," would say "me want." For a day or two he was free from any fresh attack; the hectic however continued, his voice became changed, and he again had several attacks of a similar nature to that described above; before each, the pulse rose, and he complained of pain at the epigastrium. The left lung now became similarly

affected to the right one; as regarded the hepatic symptoms, he seemed to improve. Nov. 16th—Had a severe attack, during which the arm became quite rigid, the jaws locked, and the speech affected. 17th—Twitching of the muscles of the face; opisthotonos, delirium. 18th—Eyes suffused; opisthotonos, subultus, and picking at the bed-clothes. 19th—Comatose; and died quite typhoid.

Dr. MURNEY introduced a boy under 10 years, with a

Chancre on the Glans Penis.

The case was brought forward from the rarity of primary syphilis in such a young subject.

Mr. H. M. JOHNSTONE presented a specimen of

Rupture of the left Ventricle of the Heart, near its apex.

The patient was in hospital to have his finger removed, but died suddenly, a few hours before the time appointed for operation. He had made no complaint of any cardiac uneasiness, and yet there was evidence of intense pericarditis. On removing a layer of lymph near the apex of left ventricle, the rupture was discovered—the lymph lying in direct contact with a coloured clot, which lay in the ventricle, and had apparently prevented the effusion of blood into the pericardium.

Dr. MOORE exhibited the recent parts in a

Case of Femoral Hernia,

on which he had operated some months previously. The patient was admitted under the care of Dr. Malcolm, for constipation, when a hernial tumor was discovered. The sac was opened; it contained no fluid, but a portion of gut, very much discoloured, being of a dark brown chocolate colour. The canal in which it was contained was much larger than usual. The intestine was returned; the bowels were acted upon; but at the end of the fifth day she sank, from peritonitis. The recent parts displayed a canal, one inch-and-quarter long, and very much indurated. Dr. Moore referred to a second case, on which he had operated in the same week, in hospital, and in which there was great difficulty of diagnosis; when the sac was opened, and nearly one ounce of clear fluid discharged, he naturally sought for the intestine, but was unable to detect it, having in fact opened, what is rarely met with—a false sac. There was still the tumor, but no appearance of an opening into the abdomen. After slight manipulation, and when about to open the true sac, the gut was returned, and the sac collapsed. The bowels then acted naturally, and the patient made a good recovery.

Dr. Moore also presented the matrix of a nail, removed in a

Case of Onychia Maligna.

In operating, he recommended the matrix to be en-

tirely cut out, as the most successful means in these troublesome cases.

He also presented tonsils, removed in consequence of their enlargement causing impairment of the functions of deglutition, articulation, and respiration. In operating, he recommended that the tonsil, being seized with a double hook, the incision should be made from below, upwards, inasmuch as we may thereby complete the operation should any interruption occur, as the tonsil would remain "*in situ*," by its upper attachment.

The PRESIDENT did not consider that there was a pressing necessity for the removal of the tonsil. He preferred attending to the general state of the constitution; and he had found that the enlargement disappears as the system becomes developed.

Dr. BAYCE objected to any operation for the cure of onychia maligna, having invariably found that he could cure such cases by removing the dead portion of nail, and strapping the toe.

ON THE MICROSCOPICAL EXAMINATION OF ABNORMAL INTESTINAL DISCHARGES.

In the first volume of the present series of the DUBLIN HOSPITAL GAZETTE,* was pointed out the great advantage of, and necessity for, microscopical examination of abnormal substances found in intestinal discharges. It will be seen by the following abstract that the same subject has been engaging the attention of the Swedish Society of Physicians:—

Her Von Düben observed—The physician is not unfrequently requested to give an opinion as to the nature of various strange substances occurring in the feces, and usually attributed by the patient to the presence of worms. Such a request is often not easily complied with, unless recourse be had to the microscope. The author had recently had occasion to examine two such excretions, which were exhibited. The one, from a patient of Dr. Mahmsten, was seen, under the microscope, to consist of macerated connective tissue, with commingled macerated muscular fibres, and fragments of vegetable substances, without any trace of exudation from the intestinal mucous membrane; wherefore Hr. Düben considered it most likely that the mass consisted of remnants of ingesta. The second excretion was from a patient of Hr. Huss, and exhibited lumps, of the size of peas and beans, nodulated on the surface. These masses seemed to be of two kinds, some being amorphous, and others round, and studded with white inequalities. Under the microscope they were seen to

* See DUBLIN HOSPITAL GAZETTE, vol. i., N.S., p. 38.

consist of fat-molecules, imbedded partly in unformed areolar connective tissue, partly in fully-developed connective tissue. The areolar connective tissue contained fully-formed fat cells. The amorphous masses, Hr. Düben thought, might possibly be exudation products; as to the round bodies, he had consulted Hr. A. Retzius, and believed with him, that they were the remains of broken-up lipomas. Hr. Düben reminded his audience that these growths are formed in the sub-mucous connective tissue; that in their growth they push the mucous membrane before them, until, supported on a more or less slender pedicle, they project into the cavity of the intestine; it was reasonable, therefore, to suppose that they might easily either be rubbed off or fall off.

Hr. Huss stated that he had not unfrequently been consulted by persons who asserted that they passed rag-like substances with the feces. The first case of this kind he had met with was that of a woman, who had consulted him some years ago, and had voided considerable quantities of such matters. Hr. Huss had since seen many cases of the same nature. In a French monograph, the name of the author of which he could not just then remember, he had seen the disease in question denominated, *Gastro-enterite chronique pseudo-membraneuse*. The symptoms of which the patients observed by Hr. Huss complained, had been, deranged digestion, obstinate constipation, colicky pains, and tenderness of the abdomen, chiefly over the cæcal region, especially after the rag-like substances had come away. As to the nature of these substances, Hr. Huss had hitherto entertained the opinion that they were false membranes formed in the intestine, and thrown off when mature. This was probably sometimes the case, particularly as Hr. Huss occasionally found these membranes assume the shape of tubes, corresponding in size to the intestine. The view now put forward by Hr. Retzius and Düben made it probable that the excretion in question may be the result of many different morbid conditions of the intestinal mucous membrane. The subject was not as yet, however, fully elucidated; and Hr. Huss promised in future to devote more special attention to such cases of the kind as should occur to him.

Hr. Tholanda mentioned a case occurring in his practice, of a woman aged 50, who voided a knotted filament a foot and a-half in length.

Hr. Düben was of opinion that the formation of false membrane on the inside of the intestine ought to produce more serious symptoms than those just described by Hr. Huss; and he requested that the members of the Society would, when such cases occurred in their practice, send the excretion to him for examination, with the history of the case.

Hr. Malmsten believed there was great necessity for caution in assuming that the unusual excreta described were really the direct products of disease. In his opinion, such matters are most

frequently portions of food—as tendons, fat, &c.—which have escaped destruction, in consequence of impaired digestion.

AMPUTATION AT THE KNEE-JOINT.—This operation is one of rarity in this country, and has been resorted to only of very late years by Mr. Syme and Mr. Fergusson. Velpeau and other Continental surgeons have spoken very highly in its favour. Mr. Fergusson recently performed it at King's College Hospital, before a very crowded theatre of pupils and visitors. The patient was a young lad, who had necrosis of the tibia from whom he removed a large piece of bone two weeks previous to the operation; the inflammation, however, extended to the knee-joint, which became filled with pus, and a portion of the head of the tibia had already exfoliated, thus showing that this process does occur in this situation, although denied by some writers. The amputation was performed by cutting across the front of the joint in a lunated course, making incisions on either side of the tibia, dissecting the skin off, and then forming a large and long flap underneath. This was absolutely necessary, Mr. Fergusson remarked, as the condyles of the femur were so wide, and required a wide flap to cover them. He then sawed off a slice of the articulating surface of the condyles. Although very rare in London, this form of amputation has been done by Mr. Fergusson several times, and he believes of all the thigh amputations that it really is the best, as such a good flap and stump are obtained. This case we watched with some interest; the stump has perfectly healed, and the boy was able to walk about the wards.—*Lancet*.

MORTALITY NOTABILLIA.—The deaths in London have exhibited a slow but constant decrease during the four weeks of February. In the week that ended last Saturday the total number registered was 1216 in the ten years 1847—56, the average number of deaths in the weeks corresponding with last week, was 1148, which, if raised proportionally to the increase of population, will become 1263. The result shows that the rate of mortality last week was rather below the average.—*Medical Times and Gazette*, March 7.

The Edinburgh College of Physicians has announced an intention of giving a prize of twenty-five guineas for the best essay on the Mineral Springs of Scotland, with special reference to their chemistry, climate, geology, topography, facility of access, and uses. The competition is to be open to graduates of the Edinburgh University and Colleges whose diplomas do not date earlier than 1855. The essays are to be sent in before the end of 1858. If scientific and accurate information so much required on this subject, be the object of the College, it is a narrow and selfish policy to thus restrict the competition. If they merely purposed offering a bonus to the students of Edinburgh, the sum to be awarded for the best essay on a subject entailing such laborious research is simply contemptible.—*Lancet*.

COMMUNICATIONS have been received from Dr. Johnson; Dr. O'Neill (Lincoln); Mr. Doyne; Dr. Brabson; Dr. McGea.

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CASES OF RHEUMATISM, IN WHICH THE HEART WAS ALSO ENGAGED.

By SAMUEL GORDON, M.B., T.C.D.

Physician to the Whitworth and Hardwicke Hospitals;
Examiner in Medicine to the Queen's University.

The following cases of Articular Rheumatism, in which the heart was also affected, have lately been observed in the Hardwicke Hospital.

CASE I.

Acute Articular Rheumatism.—Symptoms of Endocarditis.—Absence of the usual physical signs.—Sudden and profuse sero-albuminous discharge from the Gastro-intestinal Mucous Membrane.—Dysentery.—Death.

It is known to all well-informed physicians, that our practical knowledge with regard to the diagnosis of endocarditis supervening on acute rheumatism, has arrived at that high degree of perfection, that we can almost anticipate its existence. To Latham and Bouillaud we are indebted for having first accurately demonstrated the value of the endocardial murmur arising in the course of acute rheumatism. The former says:—"All may seem to be going on well; the chest may be free from pain; the heart's action may not awaken suspicion by its force or irregularity; nevertheless, its internal lining may be inflamed; and if you listen, the endocardial murmur may carry the momentous fact directly to your ear."*

This would seem to be a great practical fact, elicited from pure physical examination; but Latham goes even farther than this, and describes "a certain length and roughness of sound as a frequent *prelude* to the endocardial murmur of endocarditis;"† and from the existence of this physical sign, "deems himself justified in acting upon a strong expectancy of the disease, before the murmur has yet unequivocally declared it."‡ Fortunately then such is the general rule, that the

physician can have the earliest possible notice of the approach of endocarditis, by means of physical examination, when the general symptoms would have supplied no information.

The following case, however, shows that in endocarditis the physical signs do not invariably precede the general symptoms; nay, more, that well-marked endocarditis may exist, and the characteristic endocardial murmur not be present.

Mary Healy, 24 years of age, was admitted into the Hardwicke Hospital, January 8, suffering from acute articular rheumatism. The pains were very severe, affecting chiefly the large joints—the shoulders, elbows, and knees. The pulse was very rapid, but small; the skin remarkably dry, and furfuraceous. She had complete loss of appetite, not much thirst; the secretion of urine was abundant, and the bowels regular. It was her first attack of rheumatism. The case was treated with opium and small doses of quinine. The patient was remarkably thin, and suffered more from the pains in the joints than her aspect or the amount of fever would lead us to imagine. Although taking opium in very large quantity, she spent night after night without sleep.

Inasmuch as the patient was labouring under acute rheumatism, the pericardial region was examined at least once daily, and no abnormal sound was ever detected; but it appears that on the fifth day after her admission into hospital, while the pains in the affected joints rather suddenly became greatly diminished, she now complained of slight dyspnoea, præcordial oppression, and palpitation. Her pulse became considerably accelerated and more full, and her countenance assumed an air of anxiety from which it was perfectly free before. At first I imagined that the case was one of pericarditis; but while for some days the general symptoms were unabated in severity, the most careful and repeated examinations failed in detecting any exocardial murmur, or any physical sign of pericarditis in any of its stages. I therefore unhesitatingly pronounced it to be a case of rheumatic endocarditis, and treated it as such, until the

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* Vide Latham on the Diseases of the Heart, vol. i. p. 105. † Page 108. ‡ Page 115.

cardiac symptoms had altogether disappeared on the 28th of January, without any endocardial murmur having been developed.

The articular affection did not so readily give way. The patient suffered very much from the pains in the joints, so that I was obliged to use in succession various narcotics and sedatives, to endeavour to procure relief from pain, or sleep. I may here observe that she derived much benefit from the use of chlorodyne, which was given in half-drachm doses, every four hours. On the 15th of February the rheumatic pains were more than usually severe, she had had no sleep all the previous night, and now looked haggard and worn. Up to this time she had never had any symptom of disturbance of the gastro-intestinal mucous membrane; but in the afternoon of the 14th she suddenly complained of pain in the abdomen, which was immediately followed by vomiting and profuse diarrhoea. The peculiar characters of this diarrhoea were, first, its suddenness; secondly, the enormous quantity of the discharge; and thirdly, its appearance. It was very similar to the flux in cholera—seemed to consist entirely of serum, with some albuminous matter. The characters of the gastric discharge were similar. This *diarrhoea serosa* was uncontrollable during the night of the 15th; on the 16th she had the aspect and all the other appearances of a person in cholera. She was thin before, but now she seemed to have suddenly emaciated to the utmost degree; her features were pinched; her eyes sunken; her skin cold and blue; her pulse gone; and her voice was scarcely audible. Stimulants (chiefly external) drew her partly from the collapse, and acetate of lead checked the diarrhoea.

In a few days she recovered altogether from the collapse, and the serous discharges were not renewed. She never afterwards complained of pains in the joints, even when they were pressed upon, and freely moved; but she was now attacked with a low form of dysentery, and under this she gradually sunk, and expired on the 3rd of March.

The pericardium was perfectly healthy. The aortic valves were slightly thickened, but they did not admit any fluid from the aorta. The right side of the heart was healthy; the lining membrane of the left auricle was opaque, soft, and very easily detached from the connective tissue beneath; the auricular surface of the valve was thickly studded with short projections of organized lymph, but the edge and ventricular surface of the valve were perfectly healthy, nor did there appear to be any effusion into the substance of the valve; the reason, therefore, was manifest why there was not an endocardial murmur, because the functions of the valvular apparatus were in no way interfered with, there was no irregularity on the edge of either the sigmoid or mitral valve, nor was there any effusion of lymph on the ventricular surface, which, passing into the apertures, could break the current of the blood.

The fact which this case proves, "that cardiac

inflammation may be developed, unattended by any evidence of valvular lesion," is not even alluded to by the generality of writers on cardiac disease. Dr. Stokes, however, observes, "This form is of rare occurrence, and I put it forward with diffidence; but I have seen cases which could not be explained upon any hypothesis except that of the absence of murmur in endocarditis."

The present case is, therefore, of great practical interest, as completely elucidating this point, upon which our knowledge has hitherto been deficient. viz.:—the exact nature of those cases in which the general symptoms of endocarditis become developed, without production of valvular murmur.

It is true that Dr. Stokes had already, in theory at least, anticipated the cause in endeavouring to account for similar phenomena; but although the case which he narrates proved fatal, he was unable to obtain a *post mortem* examination.

The following remarks on the subject will be found in his work "*On Diseases of the Heart and Aorta*":—"We have seen that the occurrence of a valvular murmur is the most important physical indication of endocarditis; but we must enquire whether it is so constant a sign as that its absence would imply the non-existence of any such disease. In certain forms of pericarditis, when a serous or purulent secretion fills the sac, the attrition murmur may not be produced; and so in endocarditis it may happen that whether owing to the nature of the inflammatory product, or to the fact that the valves escape alteration, there may be, for a time at least, absence of valvular murmur."

The mode in which this case proved fatal is not altogether devoid of interest.

The sudden cessation of all the articular affection at the moment when the visceral complication appeared, would suggest that there was some relation between those two diseased states.

The visceral complication divides itself into two distinct parts: first, the gastro-intestinal flux; and secondly, the intestinal inflammation or dysentery.

The extreme suddenness of the former; its supervention without any apparent external cause [she had never left her bed; was not exposed to any cold; her diet was most carefully attended to; she had not taken any mercurial or other irritant medicine; nor had she suffered any sudden mental emotion]; the nature of the fluid discharged; the sudden, complete and permanent relief to the previously severe articular affection; all clearly indicate a capillary exudation from the mucous surface, analogous to that which so frequently takes place in rheumatic fevers, from the cutaneous and serous surfaces. The peculiarly dry and arid state of the skin, in the present instance, may have prevented the exhalation from taking place on the cutaneous surface; and the treatment directed to the heart for the cure of the endocardial affection may have ejected it from the pericardium; and so the gastro-

* See page 103.

intestinal mucous membrane became its seat. The appearance of the discharges, particularly those from the stomach, were exactly similar to the fluid effusions often seen in the pericardium in those who have died of rheumatic pericarditis.

The *post mortem* examination showed the mucous membrane of the stomach, and upper portion of the intestinal canal, to be considerably congested in various places; while the lower portion of the ileum, and all the large intestine, exhibited the usual anatomical appearances of aggravated dysentery, in the variegated hues and irregularity of mucous surface, and thickened submucous cellular tissue.

The supervention of dysentery on acute rheumatism is not of very frequent occurrence. It will be found, however, that at least since the time of Stoll,* authors have acknowledged a certain connexion to exist between these two affections. I have seen so many cases of *chronic* rheumatism to terminate by a fatal dysentery, that I am necessitated to place the two diseases in the relation of cause and effect, but whether as an ordinary or specific cause I cannot say; but I have never observed an acute dysentery to alternate with an acute articular rheumatism, as so accurately described by Chomel†, and which induces him to consider a metastasis to the mucous membrane of the intestines as not an uncommon occurrence in rheumatism. In the present instance the gastro intestinal flux was clearly associated with the rheumatic affection, the irritation being suddenly translated from the joints to the mucous membrane, when the extreme capillary congestion gave rise to profuse choleraic discharges, on which, as is often the case, a fatal attack of dysentery supervened.

SIMPLE ULCER OF THE STOMACH.

By ROBERT MAYNE, M.B.,

Lecturer on Practice of Physic at the Carmichael School of Medicine, and Physician to the Hospitals of the South Dublin Union Workhouse.

Simple ulcer of the stomach is a disease which possesses uncommon interest for the physician; its fatality is great, its symptoms are often equivocal and then its diagnosis becomes proportionately difficult, the final catastrophe is frequently sudden and unexpected, and its cure (for a cure may be had) is often tedious, and at best, uncertain. Its history (thanks to the labours of Cruveilhier and other writers) is now tolerably well known, and yet, perhaps, the following case may prove not altogether uninteresting, because it illustrates a rather uncommon termination of this complaint.

On the 16th of last December, Michael Cavan was admitted into the hospital of the South Dublin Union Work-house.

His appearance indicated some serious disease, for his countenance told of lengthened sufferings; he was greatly emaciated, and his colour was anæmic, like that of a chlorotic female.

On inquiring into his previous history, it appeared that he was formerly a servant in a gentleman's family, latterly a shop porter or messenger. He had never been addicted to the inordinate use of spirituous liquors; but in his last situation, which was a very laborious one, he had suffered much from daily exposure to wet and cold.

His disease commenced exactly eighteen months ago, with symptoms of impaired digestion. So long as his stomach remained empty he was free from uneasiness; but immediately after eating he was seized with symptoms of gastric irritation. He used then to complain of soreness in the region of the stomach, referred to a spot below the ensiform cartilage, and to the right of the linea alba. This soreness seldom amounted to actual pain; but it sometimes produced so much uneasiness as to make him dread the periods of his meals. His stomach used also to swell after his meals, producing a most distressing sensation of fullness, accompanied by eructations, and occasionally by pyrosis.

In addition to these ailments he had long suffered from vomitings. At first his stomach used to reject its contents at lengthened intervals only; but latterly and gradually the vomitings had become more and more frequent, *until at last they recurred regularly once in every twenty-four hours.*

His daily alternations of suffering and of ease were most remarkable. On wakening in the morning he was perfectly free from uneasiness; immediately after breakfast his distressing sensations commenced; throughout the day he had no respite; after dinner his sufferings were still further aggravated; about 10 o'clock at night the stomach usually rejected its contents—this brought him the most manifest relief—and he then slept quietly until morning. The materials rejected from the stomach were in enormously large quantity; they were semifluid, yeasty-looking, and of a sour smell.

As might have been expected from such very imperfect digestion, his flesh began gradually to waste away, his strength rapidly declined, and he was finally obliged to seek refuge in hospital.

On this man's admission, he was carefully examined, and the following additional particulars relative to his case were ascertained.

Whilst the digestive process was going on, the stomach was always enormously distended with air and fluid. The results of percussion and auscultation made this perfectly certain, for the abdomen was at such periods manifestly swollen *over the region occupied by the stomach, and no where else*; and this swollen portion of the abdomen emitted a tympanitic sound when percussed, and a gurgling sound (a species of gargonillement)

* *Vide Ratio Medendi*, iii. 144.

† *Vide Obs.* xvii. and xxiv., *Clinique Medicale*, T. ii

when forcibly compressed by the two hands alternately.

The abdomen was also frequently explored when the stomach was empty, but there was no tumour to be detected either in the neighbourhood of the pylorus, or elsewhere in connexion with the stomach. There had never been gastric hæmorrhage, nor melæna. Finally, the bowels were in a state of habitual torpor.

On reviewing the history of this man's case we considered ourselves justified in arriving at the following conclusions:—

1st—That there was some organic obstruction to the progress of the alimentary matters; for on this supposition alone could the periodic vomitings be explained.

2nd—That this obstruction was probably situated at or near the pylorus, because the uneasiness was referred pretty nearly to the site of the pylorus; and besides, the food remained in the stomach for such a lengthened period before being rejected as to countenance this conjecture.

3rd—That there was an enormously enlarged stomach; because independently of the physical signs, which of themselves afforded upon this point sufficiently conclusive evidence, none but a very capacious stomach could possibly have contained the excessively large quantities of materials rejected daily by vomiting.

4th—That the disease was probably *not* cancer, because the man was only 24 years of age; a period of life at which cancerous disease is uncommon.

Various plans of treatment were tried with this man unsuccessfully. Milk and eggs were the dietary which agreed best with him. The preparations of silver and of bismuth proved positively injurious, and so did iron. Prussic acid was at first of use in allaying gastric irritation, but it soon lost its effect. On the whole, he derived more benefit from pills containing extract of conium and powdered aloes than from any other treatment; the gastric irritation having been mitigated, and the tendency to constipation lessened by this combination.

It was but too plain, however, that nothing was likely to afford him permanent relief, for his emaciation became extreme; his weakness rapidly increased; his countenance assumed a sunk expression; and he died at length, apparently from sheer exhaustion.

The *post mortem* examination showed that the cause of all this suffering had been a small semilunar ulcer in the stomach, situated on its posterior wall, in the immediate vicinity of the pylorus. In length this ulcer was about one inch and half. Transversely it measured, at its widest part, about three quarters of an inch. Its concave margin was closely related to the pyloric orifice of the stomach, which it more than half encircled. The edges of the ulcer were abrupt. Its surface was deeply excavated, just as if a portion of the coats

of the stomach had been removed by a gouge. The mucous membrane of the stomach, up to the very margin of the ulcer, was perfectly healthy, presenting no traces of the fungoid growths which belong to cancer of the stomach. The depth of the ulcer was more than sufficient to have caused perforation; but this casualty had been prevented by firm adhesions between the stomach and the first portion of the duodenum—the duodenum, in fact, forming the floor of the gastric ulcer.

The pyloric orifice of the stomach was so much contracted that nothing larger than a middle sized catheter would traverse it; all attempts to introduce even the little finger into it were perfectly fruitless. The cause of this constriction was very plainly the encroachment of the ulcer.

The remaining appearances noticed in the dissection may be described in a very few words. The stricture at the pylorus had produced marked effects upon the rest of the alimentary canal. *All the parts above the stricture were enormously dilated and hypertrophied. All those below the stricture were contracted and atrophied.* The capacity of the stomach was enormous; its coats were greatly thickened and leathery. The cardiac orifice, in its great size, contrasted remarkably with the pyloric orifice; and even the œsophagus was greatly dilated and hypertrophied. Beneath the pylorus all was in the opposite extreme. The dimensions of the large intestine were so reduced that it was at first mistaken for a portion of the small intestine; and the small intestine, in its turn, was found proportionately atrophied.

This ulcer is a good example of what has been called the simple, chronic, perforating ulcer of the stomach. Simple it was, for nothing either in its history or appearance warranted the supposition that it was cancerous. Chronic it was, for the symptoms had been of 18 months' duration. Perforating, it most assuredly would have been, had not the duodenum, by its adhesion to the stomach, fortunately come to stop the gap. It was solitary, semilunar in shape, and situated on the posterior wall of the stomach, and in all this there was nothing unusual; but it proved fatal without producing either perforation or hæmorrhage, and thus it departed somewhat from the ordinary course of ulcers of its class.

We may fairly assume that the constriction of the pyloric orifice of the stomach was the cause of death in this case, for the symptoms were almost exclusively those of an obstructed pylorus. So tight was the stricture that the chyme must have passed through it, in quantities too small to nourish the system, and hence this man's extreme emaciation, he was starved, as it were, in the midst of plenty. The constipation, or rather the apparent constipation, arose from the same cause; *the evacuations from the bowels were scanty, because the bowels contained little or nothing to be evacuated.*

The probable result of the further progress of the ulcer in this case, *had the patient survived a*

little longer, forms a curious subject for speculation. As it was, the floor of the gastric ulcer was formed by the duodenum, and between the stomach and the duodenum very firm adhesions existed all around the circumference of the ulcer. What suppose the thin partition between the stomach and the duodenum had been destroyed by the ulcerative process, and that a new route for the chyme had thus been established?

LECTURES ON DISEASES OF THE STOMACH.

By DR. LEES,

Physician to the Meath Hospital, Lecturer on Practice of Medicine.

VOMITING.

I will now proceed to consider the subject of vomiting—a very distressing, and often a very prominent symptom, not only of various morbid conditions of the stomach itself, but also of disordered states and diseases of remote parts of the system. I will not enter into the question of its physiology, but commence at once with its pathology and causes. Vomiting may be divided, as to its causes, into—1st, Essential; 2nd, Morbific; 3rd, Mechanical; 4th, Sympathetic; 5th, Nervous.

1st—Essential vomiting is caused by some derangement in the natural secretion of the stomach itself, or by congestion, inflammation, or some structural change in that viscus; and may arise in every degree, from the simplest form of indigestion, to the most violent degree of inflammation caused by the action of irritant or corrosive poisons. In scirrhus degeneration, and in every form of ulceration of the stomach, whether simple follicular, perforating, or malignant, and also in that chronic softening of the mucous membrane, which often occurs in the advanced periods of tubercular phthisis, and which is considered by Dr. Budd to take place after death, from the action of the gastric juice, which has been excited by reflex nervous influence. But I do not agree in this opinion, for I think that the symptoms, in most cases, indicate a deranged condition of the mucous membrane of the stomach, probably an effect of the tubercular diathesis; and you will often find that a drop of creasote, or five to ten drops of medicinal naphtha, with a few drops of compound tincture of cardamoms, will relieve it. Dr. Turnbull recommends in such cases a combination of bismuth with gallic acid and opium; and Dr. Seymour (late Physician to George's Hospital) gives four grains of extract of conium two or three times a day, followed by an ounce of lime-water.* The treatment for the other forms of essential vomiting will of course depend

on the causes that excite it, and which I have spoken of in the preceding lectures on these subjects; but, as a general rule, a proper regulation of diet is of the greatest importance, which should be given in small quantities, (in a liquid or pulpy form,) and of the mildest kind. 2nd—Morbific vomiting, under which term I include every case caused by a morbid state of the blood, as we see in scarlatina, variola, erysipelas, purpura, pyæmia, cholera, yellow fever, jaundice, and other diseases, in which an effort is made to eliminate some “*materies morbi*” from the system, through the gastric-mucous membrane. Dr. Budd has alluded to this form, but only with reference to granular degeneration of the kidney; but I think it is applicable to a much greater number of diseases, and deserving of particular attention for its diagnosis, prognosis, and treatment. The history of the case, the nature of the matters vomited, and the condition of the urine, will assist us in our diagnosis, when our treatment must depend on the nature of the case; but as a general rule we should keep up a good action of the skin at the commencement, and in some cases act on the intestinal canal by purgatives, so as to try and expel the noxious material through that channel. 3rd—Mechanical. Under this head I would include those cases of vomiting which occur in consumption, bronchitis, and pertussis, simply from the violence of the cough causing spasmodic action of the diaphragm and other muscles; also cases caused by distension of the stomach from solid, liquid, or gaseous substances; or owing to pressure applied externally on this viscus by an enlarged liver or spleen, or even from stays being too tightly laced. Certain trades also, by requiring a stooping position, and so compressing the stomach, may cause it; and any mechanical obstruction to the passage of food out of the stomach, or during its progress through the bowels, will have the same effect; but in this latter case the peristaltic action of the intestines is sometimes inverted; their contents pass up into the stomach, and then we have what is termed stercoraceous vomiting; that is, matters vomited having the taste, colour, and smell of faecal matter. This condition is most frequently met with in strangulated hernia, but also in that disease termed ileus, or “*passio iliaca*,” for which Dr. Seymour recommends two grains of calomel made into a pill with one grain of soft and recent extract of opium, and followed by soda-water in active effervescence. In these cases you should try to determine towards the bowels, by means of calomel and aloes, with hyosciamus, and by enemata. If these fail, have recourse to galvanism, which I have seen followed by good results. The period of time (after taking food) at which the vomiting occurs, and the nature of the matters vomited, will be our guides in the diagnosis. 4th.—Sympathetic, by which I mean a form of vomiting caused by disease or irritation in some part of the system remote from the stomach, which itself is

* Dr. Budd recommends 15 grains of bicarbonate of potash, or 15 drops of liquor potassæ, to be taken two or three hours after meals, or some vegetable astringent before meals.

free from disease. The nausea, in these cases, is generally very distressing; the vomiting very severe, and sometimes uncontrollable till the exciting cause is removed. In some cases the vomiting is merely symptomatic of irritation produced by a natural process, as in that which so constantly occurs in the early periods of pregnancy, which, though in most cases only a temporary inconvenience, the result of sympathetic irritation, yet occasionally becomes so constant and distressing, as to require every exertion in our power to control it,* and in many cases has proved fatal; so that the induction of premature labour has been recommended by many eminent accoucheurs, as the only means of saving life. In a lengthened discussion which took place in the Academy of Medicine at Paris, in March, 1852, M. P. Dubois (one of the most eminent practitioners in that city) discussed the question with great ability; and after proving the great danger of such cases, ten of which had proved fatal within his own observation, he advocated the practice of inducing abortion, even when there was fever present, as *post mortem* examinations have proved, that even in these cases, there is no evidence of inflammation, either in the stomach or in any other part; and he quoted many cases in which all vomiting and fever had subsided, when the mother had ceased to feel the motions of the infant, which was expelled dead by the natural efforts, in some days after, when abortion occurred spontaneously. Vomiting is well known to occur as a symptom of disease in the brain, acute or chronic; but the history of the case, the pain of head, the dilated pupil, and the slow, labouring pulse, will generally put us on our guard respecting it. The late Dr. Graves, of this city, has made some important observations on vomiting, as indicative of cerebral disease in fevers. He states, that whenever typhus fever, scarlatina, variola, or measles set in with severe vomiting, unaccompanied by distinct evidences of gastric inflammation, it indicates an approaching dangerous congestion of the brain; and "*in all feverish complaints, when, during the course of the disease, the stomach becomes irritable without any obvious cause, and when vomiting occurs without any epigastric tenderness, you may expect congestion or incipient inflammation of the brain or its membranes.*" He considers that the very great quantity of bile vomited is characteristic of this form, which he termed cerebral vomiting, and which ought to be treated by leeches to the head, and other remedies for cerebral inflammation. Vomiting may be symptomatic of a calculus in the kidney or ureter, but the diagnosis is seldom very difficult, as the situation of the pain in the region of the kidney, or in the direction of the ureter—its sudden nature and intensity, coincident with severe vomiting, *but a*

quiet pulse—will generally enable us to form a correct opinion; but in cases where the vomiting is caused by disease in the kidneys, without any calculus—or even if there be a calculus, and yet so situated as not to cause any pain or tumor—there is often great difficulty in the diagnosis. We must examine particularly into the previous history, and institute a careful inquiry into the present symptoms, as well as a minute investigation as to the state of the urinary secretion, before we can venture on any positive opinion. The following case, which occurred under my care, is a good example of this:—

William Clarke, a car-driver, was admitted into the Meath Hospital for bronchitis. On going round the wards, I observed this man vomiting, and on inquiring as to the cause, he said he vomited constantly, and attributed it to his cough. On investigating his case, I found that he suffered from constant dull pain in the right lumbar region, with severe pains in his feet, and vomited every morning, but passed urine without any annoyance. He stated, however, that he was formerly a soldier, and that in Africa, twenty years ago, he contracted fever, and at that period suffered from some urinary affection, having occasional retention, with severe pain in the loins and region of the bladder. He was discharged, and gradually recovering, continued in good health till about six years since, when he was attacked with severe pain in the lumbar and pubic regions, accompanied by obstinate vomiting, which persisted for three days, when, after violent straining, he passed a small stone by the urethra. The urgent symptoms immediately subsided, and he continued free from suffering till about three months since, when the symptoms of which he now complains made their appearance. The urine was found to be large in quantity, of a pale opaline colour, alkaline immediately after being passed; specific gravity, 1.007, albuminous. A copious deposit of white sediment subsided to the bottom of the vessel, while an iridescent pellicle floated on the surface. On submitting the urine to microscopic examination, large triangular prisms of the triple phosphate were seen, with amorphous phosphate of lime. I made the diagnosis of a calculus in the right kidney, and put him on a generous diet, with dilute nitric acid, and mild counter-irritation to the right lumbar region, under which treatment he was progressing favourably, when unfortunately he was attacked with erysipelas of the face and fauces, which terminated in death. Both kidneys presented evidences of considerable congestion. In the right one, firmly embedded in its substance, there was a calculus the size of a lozenge, elongated, curved at its extremity; and the whole cortical substance of the organ appeared to be undergoing the process of granular degeneration. The mucous membrane lining the pelvis of the kidney and commencement of the ureter was of a dull white colour, and slightly thickened. The vomiting was caused, I

* Professor Simpson, of Edinburgh, informs me that in such cases he has given the oxalate of cerium in a small pill of two grains, three or four times a day, with good effect; he regards its action as "sedative-tonic."

feel confident, in this case, by the mechanical irritation of the tubular structure of the kidney, owing to the calculus; and in this irritation the stomach participated, through the influence of the splanchnic nerves, from which both the renal and gastric plexuses are derived.

DISLOCATION OF THE FEMUR BACKWARDS.—REDUCTION BY ROTATION.

By W. COLLES.

Surgeon to Stevens' Hospital.

Pat. Murphy, a strong muscular man, *ætat* 30, was admitted into hospital on Wednesday, 11th March. While carrying a sack of corn, his left foot slipped outwards, the sack fell, and in its fall struck him on the outside of the left thigh and hip.

I saw him about six hours after the accident, and found him lying on his back, the limbs semi-flexed, the left very much inverted. The foot was turned inwards; the great toe of the left foot rested on that of the right; the ankles could not be approximated; the left knee was also inverted, the inner edge of the patella lying on the patella of the right knee, and slightly above it. The thigh lay in a very oblique direction, as if in front of and in a line crossing the right. In front, where it joins the pelvis, was a large projecting mass of muscle. The pelvis was somewhat higher on this side than the opposite. The hip was much less prominent outwardly, but was increased materially in breadth from before backwards, when compared with that of the opposite side. The trochanter was felt slightly in front of its natural position, and retained the ordinary distance from the spine of the ileum; it was, however, much closer in to the pelvis—much nearer to the mesial line of the body than the opposite one. By pressure exercised behind and below the trochanter, the round head of the femur could be felt with some difficulty, as it seemed sunk in a hollow, and pressure on it caused considerable pain.

On attempting to move the limb, it was found it could not be rotated outwards; the fixed position of the bones, and the great pain caused by the effort, prevented it; from the same obstacles the thigh could not be straightened. Flexion of it was more readily performed, and the trochanter was felt to move in an upward direction towards the spine of the ileum, as if moving from the centre point of the head of the bone, which was felt also to move without changing its position. On rotating the limb forwards, the head of the bone was made much more perceptible; and if along with this it was adducted or drawn more across the other, the head of the femur could be very plainly observed. On measurement from the spine of the ileum to the upper edge of the patella, there was a difference of half-an-inch, the injured limb being the shorter.

From these symptoms and appearances we concluded that the head of the femur had been dislocated into the sciatic notch. The man was carried into the operation theatre, where the apparatus was prepared for reduction. Before, however, using the pulleys, I thought it would be right to attempt reduction by the process of rotation, although I thought the position of the head of the bone rather unfavourable for this manoeuvre. The man was put under the influence of chloroform. He was then placed lying on the right or sound side, and standing in front of him I bent up the left knee towards the abdomen; this motion was performed without any resistance, or requiring any force: I then passed my left arm under the knee-joint, and with my right hand seized the ankle; and caused rotation of the bone by raising the left arm, and at the same time depressing the right hand. On using a very trifling degree of force, I felt the bone to grate over the surface of the pelvis, and then to give the peculiar jerk and snap which is the most satisfactory evidence of reduction. This sudden noise and motion were heard and seen by all in the room. On letting go the limb, the man turned on his back, and the limb lay alongside the opposite one, its appearance and motions perfectly restored.

In general I think the injury that is produced when the limbs are separated and a heavy body strikes the outside of the hip, is a dislocation into the thyroid foramen; in the present instance we can account for the form of dislocation, by considering that the man's body was inclined forward, both from the weight he was carrying and the motion onward. On feeling the limb slip he let the sack go, and threw the body more forward and to the left side, and so directed the head of the femur backwards, or rather moved the sciatic notch so as to place it in the direction in which the head of the femur was driven by the blow; or rather, whereby its further motion with the body was prevented, the trunk still moving forwards. This case shews that we may account for the different opinions expressed by surgeons as to the lengthening or shortening of the limb in this dislocation. The limb here was half-an-inch shorter than the opposite. Had we been able to straighten it, I am satisfied we could have added at least one inch to the length, for the trochanter would have been moved downwards, describing the arc of a circle, with the head of the femur as its centre, which now was below and behind, but on the same plane.

The limb being flexed, the points of measurement were brought nearer together; because the angle which the bones formed on flexion was so much farther back in the injured than in the sound limb. And again, in the injured limb the trochanter lay close to the pelvis, nearer the central axis of the body, nearly under the line of measurement; while in the sound limb it was an inch or two external to this point.

The very great ease with which the dislocation

was restored, contrasts most favourably with the former proceedings, where the surgeon was compelled to resort to forcible extension by means of pulleys, this extension maintained for a considerable time, and often requiring the aid of copious bleeding and tartar-emetic. One consideration may enable us to account for the ease and success of the operation, that is, the great power the surgeon has of acting on the articulation, on account of the great length of lever he uses to move the short head and neck of the femur.

I would also direct attention to the beneficial influence of chloroform, which so materially assists by preventing any muscular action. We know that without this aid the muscles would resist most powerfully, and perhaps frustrate the efforts of the surgeon; and therefore, although perhaps in the opinion of some, neither the pain inflicted nor the length of time required for the reduction would be sufficient to justify its use, yet it is a most valuable, and almost necessary adjunct, as it enables us to overcome all muscular resistance so easily and effectually.

ANEURISM OF THE AORTA,

FATAL FROM BURSTING INTO THE TRACHEA.

By THOMAS H. BABINGTON, M.B.

Surgeon of the County Infirmary, at Londonderry.

L. Kelly, æt. 36 years, fireman on board a steamer, was admitted into the Londonderry Infirmary on the 28th of November, 1856, complaining of cough and some difficulty of breathing. On examination there was no heat of skin; pulse 76, same at each wrist. He had a short cough, without expectoration, the left side of his chest was clear on percussion, and there was long, loud breathing, with some bronchial wheezing. The right side was dull on percussion, with feeble, indistinct respiration throughout the lung, and very dull in upper lobe. There was heard under the right clavicle, and right side of the sternum, a distinct double pulsation and double sound, corresponding to and following each pulsation of the heart. There was no murmur; no turgescence of the veins; no bronchial or tracheal stridor; and the dyspnoea was not very urgent. On looking across the chest from the left a distinct swelling was observed under the clavicle, and a fulness was also detected on passing the hand over the breast. The pulsation could not be recognised by manual examination, except above the sternal end of the clavicle. There was no œdema of the arm. He stated he had observed this swelling about a year since, and that it had gradually increased. He only complained of cough, occasional difficulty of breathing, and a dull, aching pain along the right clavicle.

He experienced considerable relief from the use of naphtha, hyoscyamus, and hydrocyanic acid; said

he was much better, and left the hospital on 24th December, 1856. He was re-admitted on the 17th January, 1857, stating that his cough was much worse, that his breathing was at times very difficult and oppressed, and that he felt as if his throat was stopped up, and that the pain under his clavicle, and along the upper part of his chest, towards his arm, was almost intolerable.

The tumour had increased considerably, and now pointed above the clavicle. The sounds and pulsations were as formerly. There was still no murmur, no venous engorgement, no stridor, and no difference in the pulse at each wrist.

Sedatives of all kinds were used, both locally and externally. He experienced but little relief. On Sunday, the 13th March, he had some frothy expectoration, tinged with blood; and same night, about 11 o'clock, he suddenly expectorated a large quantity of blood, and expired.

Post mortem examination.—On opening the chest the left lung was observed much increased in size. In the pleura of right side there was above a quart of effused serum. The aneurismal sac was observed underneath the sternum, firmly adherent to the upper part, and to the sternal ends of both cavities, and to the ends of the first, second, and third ribs. The adherent portions of these bones were removed, with the heart and right lung. The structure of this lung was more solid and condensed than in health. On opening the aneurismal sac, it was nearly filled with solid fibrine, deposited in layers from before, backwards; on removing this it was found that the sac arose directly from the aorta, at its very commencement, and that death was occasioned by its having opened into the trachea, at the right side, where the rings are absent. The aneurismal sac measured in length 6½ inches, and from side to side 4 inches. The contained mass of fibrine weighed 1lb. 8 ounces.

PATHOLOGICAL SOCIETY OF DUBLIN.

A meeting of the Pathological Society was held on Saturday, February 7th,

The President, Dr. CORRIGAN, in the Chair.

Rupture of the Heart.

Dr. O'FERRALL exhibited a drawing and preparation illustrative of a variety of rupture of the heart, which, in his opinion, has not been before described. The lesion consisted in fatty degeneration of the anterior coronary artery; rupture of one of its branches; injection of the cellular tissue, forming a clot round the vessels and nerves; and, finally, rupture of the serous covering of the heart.

The case was that of a man fifty-five years of age. His friends stated that for the last two years he looked pale; but his habits of exercise continued uninterrupted until two days before his death. At this time, not feeling so well as usual,

he stayed in bed; and took some aperient medicine. On the day of his death he was lying in bed, at about 10 o'clock in the morning, talking cheerfully with his friends; soon after his breathing was remarked to become frequent; he, however, made no complaints, nor did he mention any thing of his sensations to his friends. The dyspnoea rapidly increased, and at length (almost suffocated) he started up in the bed, his face flushed, and his eyes having a staring expression. He cried out, "Take me out of bed!" "Put a blister on my chest!" "Open the window!" And after other expressions of distress the pallor of death overspread his features; he was lifted back into bed, and in a few minutes expired.

On opening the body after death, and slitting up the pericardium, a rent two inches long was perceived on the anterior and upper surface of the heart, along the line of the septum. The edges of the rent were separated about half-an-inch, and between them projected a firm clot, the upper and lower portion of which were the color of dark venous blood; the middle had the appearance of fibrine. The heart was then carefully removed for further examination. On opening the cavities the right auricle and ventricle were found over-distended with dark fluid blood; the left cavities were perfectly empty. There was no communication whatever between any of the cavities and the ruptured surface of the heart. The substance of the heart itself presented the tawny color of what is termed fatty degeneration, and was so soft as to be lacerated by the slightest force. A probe passed into the anterior coronary artery, went down through the clot, and shewed that the trunk of the vessel was intact. Very careful dissection demonstrated one of its branches ruptured, and presenting an open mouth in the middle of the clot; the texture of the artery and its branches was so brittle, that the slightest force broke them down. The aorta was remarkably thin, friable, and presenting a layer of steatomatous matter beneath its lining membrane. The valves were all perfectly healthy. There was no blood in the pericardium, but there was about two ounces of serum, which had scarcely a sanguineous tinge. Dr. O'Ferrall said that various forms of rupture of the heart had been described, viz.:—perforating rupture; interstitial rupture (or the "cardiac apoplexy" of Cruveilhier); and rupture of aneurism of the coronary artery. The case now presented exhibits the rupture of a *branch* of the coronary artery, without any previous aneurismal formation; and caused by the peculiar degeneration of the coats of the vessels which, when occurring in the brain—as described by Mr. Paget—occasionally gives rise to apoplexy. All these ruptures of the heart appear to be connected with one common lesion, that degeneration which has been called fatty, but which he would prefer terming lardaceous or oleaginous degeneration, in order to leave the term "fatty heart" for that condition which con-

sists in a deposit of fat on the *surface* of the heart, and which he had sometimes found in combination with a considerable degree of firmness of the muscular fibre beneath it.

The Dublin School has done much in elucidating this subject. Dr. Robert Adams took an early and efficient share in this inquiry, and since that time Professors Smith and Stokes have enlarged the sphere of our knowledge. The manner in which it destroys life was well explained by the specimen before the society, when taken in connexion with the history of the brief struggle which preceded death. A heart weakened by oleaginous degeneration, and performing its functions feebly, becomes suddenly embarrassed by the pressure of a coagulum upon the vessels and nerves supplying its right side; thus a partial paralysis of the right side of the heart is produced; and these cavities contracting feebly or not at all upon their contents, become over distended with blood, as was found in this case. This condition may be supposed to be connected with the symptoms of suffocation, and suffusion of the face, which marked its first stage. The right side of the heart ceasing to propel the blood, the systemic vessels must of course become gorged; and the countenance, most probably, at that moment, indicated this condition. The dyspnoea is easily explained. Then comes the secondary consequence of this over-distension of the right side, viz.:—the want of arterial supply into the *left* side of the heart. The left side of the heart not receiving its usual quantity of blood, the brain must consequently cease to have *its* necessary supply; and here comes the explanation of the sudden pallor and death by syncope.

It is probably that the hæmorrhage took place so slowly as to allow a coagulum to form before the serous membrane gave way, and this circumstance, together with the fact of the hæmorrhage having occurred from a small branch, would account for the absence of colored blood in the pericardium. Dr. Robert Adams, in the *Dublin Hospital Reports*, has alluded to this paralysis as a consequence of deficient supply through ossified or calcareous coronary arteries. It is probable that in the present case the pressure of the clot upon the vessels and nerves occasioned a deficient supply, both of nervous influence and arterial blood, to the right side of the heart. The present case is therefore remarkable as explaining, by its morbid anatomy, the brief series of phenomena that occurred before death; and as adding one more variety of rupture of the heart to those already described.

Fracture of the Pelvis.

Dr. THOMAS HAYDEN brought forward a morbid specimen which had presented all the external features of a fracture of the neck of a femur; upon dissection, however, it proved to be a fracture of the left os innominatum passing through the acetabulum, and extending inwards to the de-

scending ramus of the pubes. The acetabulum, which was fractured through its centre, appeared driven inwards, as if from some force applied to the great trochanter, and nature had attempted to unite the fracture by a growth of bone of very irregular form, which was thrown out between the fragments. At the lower and back part of the ilium there was a remarkable canal in the osseous growth, (which was thrown out on every side,) divided into two compartments for the transmission of the gluteal and sciatic vessels and nerves. The acetabulum was deepened and pushed backwards and upwards. The head of the femur, which was greatly reduced in size, was entirely denuded of cartilage at its posterior inferior surface, which was rough and flattened; the capsular ligament was hypertrophied. The fracture seemed to have been caused by a fall upon the great trochanter. The specimen, however, was procured from a subject in the dissecting room, and it was found impossible to obtain any history of the case.

Perforating Ulcer of the Stomach.

Professor BANKS presented a specimen of this lesion, and detailed the following facts:—A woman aged 40, was received into Sir Patrick Dun's Hospital, late in the evening, having been ill since 8 o'clock in the morning. She was a strong and extremely well-formed woman; her health, she said, had been good; but she had received a slight injury of the side, from a fall, six weeks previous to the illness for which she was admitted into the hospital. On the morning of the day she came to the hospital, she was engaged in her usual work, as housemaid, when she was seized with symptoms which led to the belief that the disease under which she laboured was peritonitis from perforation. The pain, which was of excruciating severity, commenced in the epigastrium, and soon extended over the whole abdomen, which was exquisitely tender on pressure. The abdomen was enormously distended; her countenance indicated much suffering; the extremities were cold; and the pulse at the wrist was scarcely perceptible. The woman died four hours after her admission into the hospital, and 17 hours from the time she experienced the first symptom of her fatal illness.

The body was examined 12 hours after death. On opening the abdomen, air escaped, and a considerable quantity of yellowish fluid flowed out; and on its surface globules of oil were observed; (castor oil had been taken by the woman, before her admission into hospital). The peritoneum, over its whole extent, presented the usual appearance of recent inflammation. On the anterior surface of the stomach, and two inches from the cardiac extremity, there was a perforation, about the size of a sixpence, perfectly circular in form. The mucous membrane of the stomach did not present any abnormal appearance, except in the immediate neighbourhood of the ulcer, around

which the coats of the stomach were thickened, the edges elevated, and remarkably indurated.

Dr. Banks observed that there were one or two points of interest connected with this case. The situation was unusual; the pyloric end of the stomach being, in the vast majority of recorded cases, the seat of the ulcer. The age of the subject of this lesion of the stomach was more advanced than is generally the case when perforation of the anterior wall of the stomach occurs in females. In conclusion, Dr. Banks observed, that ulcer of the stomach, judging from his experience, was not frequent in Dublin, more particularly as compared with the number of examples of the disease met with elsewhere.

ABSTRACT OF THE PROCEEDINGS OF THE BELFAST CLINICAL AND PA- THOLOGICAL SOCIETY.

SESSION 1856-7.

Sixteenth Meeting.

The President, Dr. M'GEE, in the Chair.

Dr. MURNER presented a well-marked specimen of

Cirrhosis of the Liver.

The organ was in the contracted stage of the disease; its surface was nodulated, and its substance firm. On examination of sections under the microscope, the fibrous element was found in very large proportion. There was no dropsical effusion; the early history was unknown.

Oedema of the Glottis in Typhus Fever.

Professor FERGUSON referred to a case of typhus fever under his care in hospital, in which, in the advanced stage of the disease, an asthenic form of oedema of the glottis had supervened, causing symptoms of a most urgent nature. The patient's strength was supported, stimulants exhibited, and a large blister applied, under which treatment recovery had taken place. Dr. F. remarked, that by some the symptoms would have been considered sufficiently urgent to demand an operation. Dr. Ferguson also introduced three male patients with

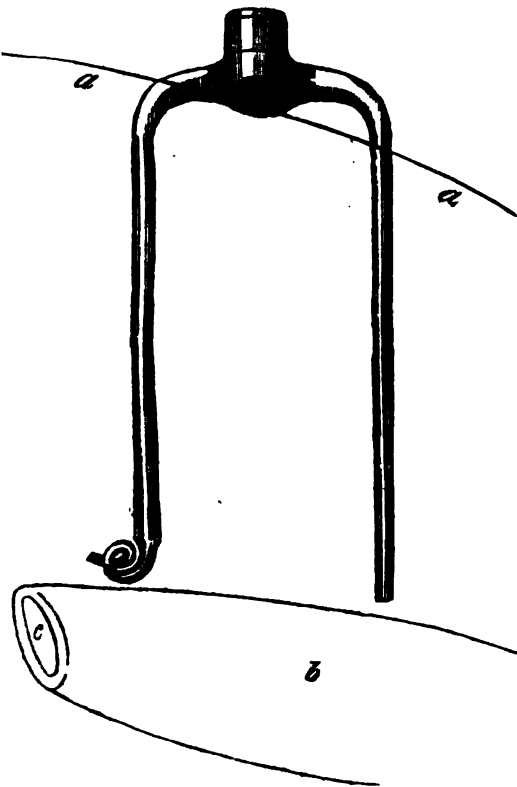
Paralysis of the superficial and deep Extensors of the Forearm and Hand.

In all the loss of power was attributed to accidental pressure, causing mechanical injury of the musculo-spinal nerve. The paralysis was strictly local, and the power of extension could, for the time, be restored to the muscles by electricity. There was very slight impairment of sensation; and Dr. F. looked upon these cases as consisting in a debilitated condition of the muscles, caused by the injury of the nerve-tube, and consequent interruption of the supply of nervous energy. The atrophied state of the muscles supported this view of

the pathology of such cases. He regarded the prognosis as favourable; and as for treatment placed most reliance in the continued application of the electric current.

Dr. MOORE presented an enlarged labium, which he had removed, and which was of a similar character to that previously shown; it also originated in syphilitic ulceration. There was considerable venous hæmorrhage and a watery discharge during the operation. The wound healed by the first intention.

Dr. Moore exhibited a spindle, which he had



a, Line of the Hip, near the Trochanter.
b, The Rectum.
c, The Anna.

removed from the buttock of a boy aged 12 years, who had by accident fallen upon it from a height. It penetrated immediately behind the trochanter major, and could be felt pressing against the rectum, on the finger having been introduced. Repeated attempts were made to pull it out; and these having failed, he was brought to hospital, where, under the influence of chloroform, a bandage being inserted beneath the area of the spindle, and traction made, it was withdrawn. The difficulty of its removal arose from its end having a brass screw attached, and turned outwards. Dr. M. preferred, if possible, to avoid interference with the knife, as he had seen a diffused aneurism originating from a deep wound in the gluteal region.

Seventeenth Meeting, February 21st.

The President, Dr. M'GEE, in the Chair.

Muscular Paralysis of Arms, &c.

Dr. SEATON REID introduced a man to the Society who was just leaving the Union Hospital, where he had been a patient for some time, in consequence of having lost almost entirely the power of motion in his arms, forearms, and hands; sensation remaining perfect. The disease in this patient had existed for several years, and appeared to belong to the interesting class of cases that had been described by Drs. Darwall, Cruveilhier, and others, under the names Muscular Atrophy, *Paralysie Musculaire Progressive*. Dr. Reid refrained from any remarks relating to this rather rare form of disease, as he intended, on some future occasion, going fully into the history of this and three other similar cases, and communicating the results of some *post mortem* examinations which had a bearing upon its pathology.

The PRESIDENT read the history of a case of

Cardiac and Hepatic Disease,

with an account of the result of the *post mortem* examination. The case will appear in full in our next issue.

Eighteenth Meeting, Saturday, Feb. 28th.

The President, Dr. M'GEE, in the Chair.

Mr. BROWNE presented a small *Neuromatous Tumour removed from the leg* of a man aged 58 years; it had been located near the head of the fibula, and was of twelve years growth, during which time he had suffered great agony in the part, the attacks being periodic for three hours each day about noon, and for the same period about midnight. The growth was evidently in connexion with a branch of the anterior crural nerve. The removal of the tumour completely relieved the patient from his long state of suffering.

Dr. HALLIDAY read the following history of a case of

Spinal Arachnitis.

Wednesday, June 3rd, I was called to visit a young lady æt. 20 years, and found her complaining of intense pain in the back, corresponding to the tenth and eleventh dorsal vertebrae—pulse 110, skin hot, thirst, tongue slightly furred. On the previous Friday, whilst feeding fowl in the yard, during a shower of rain, her dress being somewhat open behind, she felt a chill down the spine which she thought of no consequence, until the following day, when she was seized with a rigor. The next day, Sunday, she was able to attend her place of worship, but felt very unwell that night, complaining of intense pain in the back, accompanied with a great sense of lassitude, and inability to move about. The catamenia had appeared on Saturday, and continued to flow, but not freely, until the time

of my first visit. The bowels were constipated, the stomach rejected even drink—*firm pressure over the spine afforded relief*—over no part of the surface was there any increased sensibility, and in very many points the case resembled one of acute lumbago; a brisk calomel purgative was prescribed, and turpentine fomentations, to be followed by a large bran poultice to the affected part. Thursday, June 4th, I found that the powder had been rejected, and a stimulating enema was administered, by which the bowels were moved. She now began to find much difficulty in drawing up her lower extremities, this, in conjunction with the want of any improvement in the symptoms above mentioned, led me to cup her on both sides of the spine, and steadily administer mercury; in addition the compound decoction of aloes was given, with a view to cause the menstrual flow. Saturday, June 6th, there was complete paralysis of motion and sensation in the lower extremities, together with retention of urine. The paralysis of sensation extended as far up, as a line drawn around the crest of the ilium. The pain in the spine now occurred in paroxysms, which were very greatly increased when she was moved—there was retraction of the head, accompanied with a mixed tetanic and hysteric expression of countenance—the pulse was only 100, and not full, and there was not the slightest pain on pressure over the spine; the calomel was continued, but its constitutional influence could not be attained, nor did it seem to have any effect over the progress of the disease. Blisters were applied, but the symptoms continued unrelieved; there were no convulsive seizures; her intellect remained perfectly clear to the last, and she seemed to sink from exhaustion on Tuesday, June 9th, being the twelfth day of her illness.

Dr. Young read the following paper

On the Tests for Diabetic Urine.

Our knowledge regarding diabetes is not altogether so imperfect as formerly. Bernard's experiments have cleared away much of the obscurity that previously hung about the question. As a general rule, sugar is always to be found in the hepatic veins, but never in the portal—so that it is now established, that one of the functions of the liver is to prepare sugar from the portal blood. What precise object the sugar fulfils is not yet accurately determined. It ought not, however, to get into the arterial circulation. When it does, part of it passes off by the kidneys, and causes diabetes. The tests are innumerable, and the practitioner is often sorely perplexed with the wearisome directions and the costly apparatus necessary to attain a positive diagnosis.

For the practical, though not the purely scientific man, the sulphate of copper, and nitrate of silver tests are quite sufficient, and will decide the point in a few moments, very unlike the yeast, the bile trisacetate of lead, the chromate of potass, the mi-

croscopic, and the bi-chloride of tin tests. These are expensive, troublesome, and tedious methods. But blue stone, and liquor potassæ, nitrate of silver, and strong ammonia, are not only cheap and simple, but may be found in every dispensary in the kingdom. Hence Jones says:—"To a drachm of suspected urine add two or three drops of a saturated solution of sulphate of copper, then two drachms of caustic potass, at first a beautiful blue is produced, apply heat, and if grape sugar be present, the oxide of copper is rapidly reduced, and reddish yellow suboxide of copper is precipitated." If the result be negative, we may be certain there is no sugar in it; but if positive, we ought to try the second one also. Place a few drops of a saturated solution of nitrate of silver in a test tube, and add one drop of caustic ammonia, then add one drop of the suspected urine, heat the tube and shake the contents, and in a few seconds the metallic lustre will appear on the side of the tube.

Reynoso says:—"Sugar is always present in the urine of the aged. I had an opportunity lately of examining this point. An old gentleman took ill and requested my advice. His ordinary medical attendant told me that the case was one of glucosuria. The sp. gr. was not very high, 1.030; in using the copper test the reaction seemed to indicate sugar, but with the nitrate of silver there was nothing of the kind—the fluid did, however, contain an excess of urates as well as urea, which will behave with the copper test very like grape sugar, with this decided difference, the changes with the latter take place almost immediately; with the former very slowly. I had therefore the satisfaction of knowing that I had not an incurable disease to deal with. But I need not observe how important it is to form a correct diagnosis, even when the prognosis must be the worst. A gentleman, well known to all here, was dying rapidly, (he was going about his usual business on Saturday, and was dead on the following Wednesday,) and it seemed impossible to say what he was dying of, but the urinometer and the two tests already given, settled our doubts, and enabled us to fortify with a melancholy certainty the hopeless issue of this formidable and intractable complaint."

Nineteenth Meeting, Saturday, March 7th.

The President, Dr. McGEE, in the Chair.

Dr. R. TEMPLETON, First-class Staff Surgeon, called the attention of the Society to the fact, that in the East an infusion of *Raspberry Leaves* is administered, for the purpose of originating uterine contraction, and seems to produce much the same effects as the ergot of rye.

Dr. JOHN MOORE read a paper on the following cases of *Fever with unusual complications*:—June 30th, 1856. James O'Neil, æt. 21 years, was admitted into the Royal Tyrone Detachment Hospital, stationed at that time at Lifford. He com-

plained of languor, lassitude, and debility; his pulse was quick, skin hot, tongue coated; there was also thirst and loss of appetite. He was put on spoon diet, and got a diaphoretic mixture, with some antimonial and grey powders night and morning. The fever was of the mildest description, and he would not have been confined to bed, had his own wishes on the matter been consulted. He progressed favourably, without much change in the symptoms, or any local complication arising, until the 5th July, when he accompanied the detachment to Omagh. On the day following he seemed better, the fresh air (as he himself said) had done him good. He continued to go on favourably until the 9th, when he was attacked by a violent fit of convulsions, which continued for nearly an hour, and momentarily threatened dissolution. There had been no premonitory symptoms that I could detect to tell of the danger that was coming; there had been no sleeplessness, headache was not complained of, and there was not the slightest tendency to delirium or wandering. On making a careful examination of the chest, however, we found considerable pleuritic effusion, with consolidation of the lower lobe of the left lung; there was no discharge, and nothing but the physical signs to indicate the presence of so much organic mischief. Dr. Thompson looked upon the attack of convulsions as arising from sympathy with the chest affection. I was inclined on the other hand to look upon them as an attack of epilepsy, occurring during the course of the fever. I was not able to learn, however, that he had previously been subject to such fits. He recovered from the convulsions, and the day following there was apparently not a trace of mischief left behind, still, no headache, nor intolerance of light, no sleeplessness nor delirium; in fact, he said that he felt nearly well; indeed, this was the only suspicious symptom of the mischief going on within the encephalon, that there seemed to be an unconsciousness of the amount of organic mischief which had taken place within the chest. A large blister was applied to the side, and three grains of calomel given thrice daily.

At my morning visit, on the 12th July, three days after the first attack of convulsions, he requested me to permit him to get out of bed, as arrangements were being made at that time for the disembodiment of the regiment, and he had his accounts to settle. I replied that I could not comply with his request, and told him that he was far from being as well as he thought he was. Two hours afterwards the convulsions returned, and quite suddenly and unexpectedly he expired.

The *post mortem* examination was made 20 hours after death. On opening the chest, more than a pint of fluid was found in the left pleural cavity, and the lower lobe of the left lung was greatly gorged with blood. On opening the head the veins of the brain were greatly congested, but the substance of the brain was healthy, the left ventricle was filled with fluid, and on removing the brain, more than 4 ozs. were

found lying at its base. This to my mind appeared to be the immediate cause of death.

In connexion with this case, I may mention that of Mrs. J., whom I saw on the 10th day of her fever. Up to that period she had been progressing favourably through a mild attack of simple continued fever. At the time I saw her there was no local complication, and the only thing complained of was want of sleep, she had then been two nights and two days without rest. An opiate was administered at bedtime, which procured a little, though not refreshing sleep. On the following day there was double vision, her attendants had two heads upon each of them, at least in her eyes; when a drink was given her, the vessel which contained it appeared like two vessels. Half a dozen leeches were now applied to the temples, a blister to the nape of the neck, cold applications to the head, and sinapisms to the calves of the legs. Mercury at the same time was given in moderate doses. After the leeching the vision was quadrupled, every thing appeared multiplied by four. There was still very slight headache, the mind was perfectly calm and collected, there was no subsultus; and the double vision was the only indication of danger present. The next morning there was slight squinting of the left eye; an hour afterwards violent convulsions set in, which speedily terminated in death. No *post mortem* examination.

I am sure that to many of you there is nothing novel in either of these cases, and the only deduction which I would draw from them is, that those changes which take place in the brain during fever, are of a passive and not an active character. Now there is a wide spread opinion abroad, that wherever the head is involved in a fever, and where, as they term it, there is congestion or inflammation of the brain present, that wine and stimulants should be most rigidly withheld. I think, however, that this is a great mistake.

ON EXPLORATION BY COMMOTION. BY M. CRUVEILHIER.—M. C. observes, that in all cases of jaundice, and in all other diseases in which he suspects the liver to be affected, he is in the habit of exploring this organ by "commotion." For this purpose, the patient is placed on his seat, and the right side of the thorax is percussed, from above downwards; the patient being desired to express himself when aware of any unusual sensation or pain. It is very rare in recent icterus, and especially in febrile icterus, for the patient not to announce a marked sensibility as soon as the percussion excites a shaking of the liver. By this means, too, an abscess of the liver, the consequence of a fall from a high place, has been diagnosticated. M. C. has also applied this mode of exploration to the kidney, spleen, heart, and even the uterus. For the brain, it may be put into place by suddenly pulling at a handkerchief that is held closely between the teeth. In this way it has been advantageously used in many cases of cerebral disease.—*Archives Generales, and Medical Times and Gazette.*

OPTUM.—The East India Company's revenue from opium in the year 1854-5 was £3,125,251.

PROF. MURPHY ON PUERPERAL FEVER.

At a late meeting of the Epidemiological Society of London, Professor MURPHY, after alluding to a former paper on the subject, in which he objected to the propriety of considering this disease as an inflammation of one or other of the tissues, pointed out that neither in the mode of attack, in the symptoms, in the *post mortem* appearances, nor in the treatment, did puerperal fever agree accurately with peritonitis. A closer resemblance to phlebitis was admitted, because both were blood diseases; but he denied that they were identical. He proceeded to explain his views of the nature of the disease, that it was the result of a poison, and obeyed strictly all the laws of morbid poisons. Its action was definite and specific; the seat of that action was the serous surfaces, especially the peritonæum and uterine veins, chiefly because of the rapidity of their absorption. He denied that the action itself should be considered a specific inflammation, although he admitted that in certain cases inflammation may be excited. The term inflammation was used too extensively, being made to embrace actions perfectly opposed to each other. The design of inflammatory action is to preserve or repair organized structure, yet the term is given to actions that destroy it. Thus, cancerous inflammation, tubercular inflammation, are expressions sometimes used in such a manner as to mean that cancer and tubercle were only forms of inflammation. So in the infantile lung *post mortem* appearances were described as lobar, lobular, vesicular pneumonia, which were caused by collapse of the lung. The tendency of a poison is to destroy organization; it is incorrect, therefore, to consider its action as a specific form of inflammation, which, whenever it takes place, is only for the purpose of limiting the action of the poison; and in this sense, just as the deposition of tubercle on the peritonæum is accompanied by peritonitis, so the puerperal poison may excite peritonitis; but the more powerful the poison the less peritonitis, and the weaker its influence the more distinctly are the evidences of inflammation observed. The action of the puerperal poison is on the blood; the quantity of fibrin is increased; the quality deteriorated. A profuse exudation of morbid fibrin takes place, having some of the properties of healthy fibrin; it is not organizable, dissolves into a creamy substance, which melts into a fluid-like pus, and mixing with serum, forms the abundant "lactescent fluid" of authors. Exudations are not found in the veins because they are not adhesive; but dissolved fibrine, like pus, is found abundantly. The puerperal poison seems a contrast to the typhus poison, which destroys fibrine; yet the typhus poison absorbed by a parturient patient will cause puerperal, not typhus fever. It is the same with erysipelas. The action of the poison is modified by the dose as well as by the temperament and constitution of the patient. Puer-

peral fever does not attack all indifferently, but selects its victims. The most important feature of this law is, the manner in which the characters of the disease are modified by the quantity of the poison absorbed. When it is in excess the patient may die without any other symptoms than a fluttering pulse and cold livid surface. On the other hand, the dose may be so small, that true inflammation is set up to arrest it, and thus peritonitis, phlebitis, or arthritis, takes place. Hence the contradictions among authors; those who meet the latter class of cases calling the disease peritonitis, while those who meet the former stand aghast at symptoms which no theory of inflammation can explain. The coexistence of whooping cough and measles, of syphilis with erysipelas, proves that two poisons may each set up their specific actions in the same person at the same time. Erysipelas and puerperal fever have occurred in the same patient; but the author generally found erysipelas to precede or follow puerperal fever rather than accompany it. Erysipelas excited puerperal fever: but when the latter was at its height, the former disappeared. The author objected to the opinion that erysipelas and puerperal fever were identical, and did not consider those cases described by Good, in which the peritonæum was pale and colourless, as puerperal fever at all: they might be instances of erysipelas, if this poison ever attacks serous membranes. The author considered the poison as a contagion, just like the cadaveric poison which seems so similar to it; and briefly enumerated the symptoms of the disease, to explain the principle which should guide us in the treatment. According to its strength, the constitution makes an effort to get rid of the poison, whether by vomiting or purging, by the skin or by the kidneys. The observation of these efforts led Douat to use emetics, Boer kermes mineral, Denuan tartar emetic, and Armstrong salts and senna. If the effort fail, the poisoned blood accumulates at the centres of the circulation, which are relieved by a prompt and bold depletion. For such a purpose, 30, 40, or even 50 ounces of blood have been taken with decided benefit; but depletion should instantly follow the rigor, because, if time is lost, the very same treatment may only hasten dissolution. Camphor and turpentine have been recommended in the treatment of this fever. These remedies are not only stimulant but anæsthetic, and are useful, not alone in supporting the constitution against the attack, but, by diminishing pain, they lessen nervous exhaustion. Reasoning on these facts, the author tried chloric-ether with great advantage, and recommended it strongly to the consideration of the profession. General rules cannot be laid down for the treatment. If the dose of the poison be a maximum, nothing will save the patient; if in such quantity that the constitution can make some effort to get rid of it, much of our success will depend upon a close observation of the manner in which the effort is made. Prompt de-

pletion has saved many a patient. The judicious use of emetics, purgatives, diaphoretics, and even diuretics, has arrested the attack by aiding a natural effort. If the dose of the poison be a minimum, then peritonitis or phlebitis becomes prominent, and must be treated as such. Thus, what are called the inflammatory and the atoxic forms of the disease merely signify the degrees in the dose of the poison. The author alluded to the importance of prophylactic agents, to ventilation, and the improvements lately introduced; to chlorine as a means of destroying the poison; and to anæsthetic agents as a means of blunting the sensibilities of the nervous system, and diminishing the activity of absorption. In this sense he considered chloroform extremely valuable, and so far from fearing its influence in causing puerperal fever, he looked upon it as a preventative.—*Med. Times & Gazette.*

QUESTIONS AT THE FIRST COMPETITIVE EXAMINATION FOR ARMY ASSISTANT SURGEONS.

MIDWIFERY, BOTANY, AND ZOOLOGY.

1. Should flooding occur during pregnancy, what would you do? and if the means you employ have not the desired effect, what would be your next step? and in the event of that also failing, what would you then try?
2. Describe what successively occurs in the human female between the time of impregnation and the final expulsion of the fœtus.
3. How long would you permit the placenta to remain after delivery? State what may retard or prevent its expulsion; and how you would proceed in each description of case.
4. Give the symptoms of puerperal fever; the usual time of its invasion; the treatment you would adopt; and the morbid appearances usually discovered when the disease proves fatal.
5. Describe the system of classification of Linnaeus, and that of Jussieu. To what parts did Linnaeus resort for his classes and orders? What parts were employed by Jussieu. Give an example of the Cryptogamia Lin., and of the Acotyledons and Cotyledons of Jussieu.
6. State the mode of growth of an exogenous and of an endogenous plant; and instance one of each description.
7. Enumerate the parts which compose the flower of *Solanum tuberosum*, and the uses and functions of each part; how the pollen escapes, and how it is conveyed to its destination.
8. What are the classes of the animal kingdom proposed by Cuvier; and what are the orders in which he arranges the vertebrate animals?
9. How would you distinguish a poisonous from a non-poisonous snake?—State in what respects the teeth of the one differ from those of the other.
10. What is understood by a warm-blooded, and what by a cold-blooded animal? Give an example of each, and state the form of the blood-globules in those you instance; state also how impregnation is effected in each. What is implied by viviparous, oviparous, and ovoviviparous, and give an example of each.

SURGERY.

1. A musket-ball has passed through the shoulder, fracturing the head of the humerus.—What would you do?

2. On cutting a flap to excise the head of the bone

in the above case, the neck of scapula and glenoid cavity are found to be badly fractured, and a longitudinal fracture is found to extend down the shaft of the humerus below the point to which your incisions reach, and apparently going considerably further still.—What would you do?

3. A man's foot has been frostbitten, and is, in consequence, dead from the toes upwards, as far as halfway up the metatarsal bones.—How would you treat it?

4. A man has been severely wounded by a fragment of shell, which has penetrated deeply into the buttock, and he shows you a large mass of iron which has been extracted. Two days afterwards he is brought to you from the front; you dress the wound lightly; and in two days' time you find him suffering from trismus.—What would you expect to be the nature of the wound, and what would you do?

5. You have performed the operation of lithotomy in the case of an old man, and, several hours afterwards, hæmorrhage to a considerable extent sets in; the blood is dark-coloured.—What the probable source of bleeding, and what would you do?

6. A musket-ball enters close to the trochanter major, fracturing the femur, and splintering it downwards for a couple of inches.—What steps would you adopt? Also, suppose another case, where the bullet, after inflicting the above injury, had lacerated the femoral vessels on the anterior part of the thigh.—What course would you follow?

7. In cases where the femur is broken by a musket-ball within four inches of the trochanter major, or lower down, and when the laceration of the integuments is not great.—How would you treat the case?

8. Suppose the abdomen were wounded, and that unstrangled omentum protruded.—What would you do? and, further, suppose a large strangulated mass were protruded, how would you act?

9. How would you perform excision of the elbow-joint? What nerve would you carefully protect from injury during the operation?

10. How would you perform the operation of paracentesis thoracis? and what would you most strive to avoid in performing the operation?

ANATOMY.

1. Enumerate the bones of the tarsus and carpus, stating their position and relation to each other.
2. Give the anatomy of the shoulder-joint.
3. What are the contents of the lateral ventricles of the brain?
4. What are the characteristics of a cervical, dorsal, and lumbar vertebra?
5. What vessels are given off from the abdominal aorta?
6. In the circular amputation of the lower third of the thigh, what parts are cut through?
7. What are the branches of the external carotid artery, and to what parts are they distributed?
8. What are the ligaments of the knee and ankle joints?
9. Give the symptoms and treatment of poisoning by arsenic; stating also the pathological appearances of the affected structures, and the tests for discovering the presence of arsenious acid.
10. Name the antidotes for oxalic acid, corrosive sublimate, and nitrate of silver.

GENERAL AND SPECIAL PATHOLOGY, AND THE PRACTICE OF MEDICINE.

1. In the course of what diseases is ulceration of the gastro-intestinal mucous membrane apt to occur; and what symptoms and signs would lead you to infer the supervention of that lesion? Detail the various positions in which it is found, the extent to which it generally proceeds, and the successive steps of that process.
2. Excluding hæmoptysis proper, describe the various kind of matter expectorated from the lungs and air passages,—specifying the diseased conditions with which

they are severally associated, their diagnostic value, and the aid to their examination furnished by the microscope.

8. Describe the mode of production and the diagnostic value of the principal auscultatory signs.

4. Describe the treatment of hæmoptysis under the various circumstances of its occurrence; and, in relation to these, give the prognosis you would form in the several cases.

5. Detail the symptoms, causes, and treatment of delirium tremens, as this disease is generally met with; and specify what peculiarity of symptoms is presented, and what modification of treatment is demanded in the disease when occurring at the close of a severe debauch in a young and robust subject.

6. Describe the etiology of scorbutus; and specify the points of resemblance, and also the differences between it and purpura,—as well as in the treatment of the two diseases.

7. What are the signs and symptoms; and the causes, proximate and remote, of abscess of the liver? Detail the course you would pursue when this becomes the prominent object of treatment.

8. Describe the treatment of a severe case of intermittent fever, appropriate for its several stages; and enumerate the various remedial agents which may be employed in that disease, specifying those under which obstinate cases have at length yielded.

9. What are the different forms of mental derangement usually met with in practice, and what are the leading features of each?

10. Suppose you were ordered to embark for Ceylon, in medical charge of a numerous draft of soldiers, with the usual quota of women and children, what general hygienic means would you recommend to be adopted for the voyage? and, in the event of an outbreak on board ship of malignant cholera, or of small-pox, what particular measures, dietetic, regimental, and medicinal, would you endeavour to carry out?

AGREEABLE MODE OF TAKING SENNA.—Dr. Linthner says that senna leaves (one or two drachms to one or two cups of water) should be allowed to infuse all night in cold water. With the strained infusion coffee is prepared next morning, as if with water; and an aperient which does not taste of senna, and does not cause griping, is thus produced.—*Buchner's Repert.*, No. 7.—*Medical Circular*.

ON THE USE OF CHLORATE OF POTASH IN MERCURIAL STOMATITIS.—At a meeting of the Société Médico-Pratique de Paris, M. Perrin described the good effects of the chlorate of potash in a case of mercurial stomatitis. In a lady, thirty years of age, attacked with acute inflammation of the uterus, mercurial frictions abundantly employed for several days on the abdomen, had produced very painful mercurial stomatitis, with impossibility of opening the mouth, of swallowing, of moving the tongue, and of speaking; and the whole of these symptoms complicated with an abundant and offensive salivation, which deprived the patient of sleep. Two grammes of chlorate of potash were prescribed in an ordinary gum-potion, and given in spoonfuls every hour. The next day there was considerable improvement; the patient was able to open her mouth and to speak distinctly for the first time for two days. Four grammes instead of two were given in a second potion. After the use of this second potion, the improvement was so complete, that there was no occasion to continue the treatment any longer. It should be mentioned that at a recent meeting of the Société Médico-Pratique de Paris, Dr. Otterbourg, without denying the good effects produced by chlorate of potash, has expressed an opinion that the borate of soda possessed equal efficacy in stomatitis.—*British and Foreign Medico-Chirurgical Review*.

TREATMENT OF ITCH.—After the trial and comparison of the various modes of treatment, M. Bourguignon accords the preference to the following formula:—Glycerine, 50 drachms; finely-powdered sulphur, 25 drachms; 2 yolks of eggs; and tragacanth powder, q.s.: adding essences to mask the smell.—*Union Médicale*, No. 156.—*Medical Circular*.

In his concluding lecture, delivered at the College of Physicians, on the subject of Diabetes, Dr. Garrod, in advocating the superiority of dietetic over any other treatment in this disease, spoke very favourably of the effects of the bran-bread, which has been described by a member of our Profession, Mr. Camplin, and prepared, under his direction, for use in some of our hospitals. This bread is made of bran, which ought to be very finely ground, mixed with butter, eggs, and milk, and leavened by hydrochloric acid and carbonate of soda. In this form it constitutes a light cake, of a brown colour, something like gingerbread in appearance, and is by no means unpalatable. In the same lecture, Dr. Garrod, adverting to the supposed efficacy of Vichy water in the treatment of diabetes, observed that, in his own experience, he had found no decided benefit from its use; and he also stated that the Vichy water sold in London contained only bicarbonate of soda, all the other ingredients being carefully excluded.—*Medical Times and Gazette*.

DIED.

On the 30th instant, after a very short illness, at his house, Granby-row, ROBERT BALL, Esq., LL.D.

COMMUNICATIONS have been received from Dr. Sata (Mullingar) with enclosure; Dr. Doherty, (Galway) with enclosure; Dr. Hughes; Dr. Hardy; Dr. B. Kennedy; H. Edgeworth, Esq.; Dr. O'Neill, (Lincoln); Dr. Brabazon.

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CLINICAL LECTURES.

By ROBERT ADAMS, M.D.

Surgeon to the Richmond Hospital.

21st February.

ON BONY CYSTS OF THE LOWER JAW.

GENTLEMEN,—I wish to call your attention to-day to two cases, in which the right side of the lower jaw was greatly enlarged. The expanded bone in each case formed a tumor, which consisted of a bony cyst; in the one instance containing a solid material, and in the other the cyst or bony shell had fluid contents.

As in both these cases the disease had been for three years steadily increasing, and we knew of no medicine capable of arresting its progress, it appeared evident that the life of the patients would ultimately be sacrificed, if amputation of the portion of the lower jaw involved in the disease were not resorted to.

The pathological anatomy of bony cysts of the lower jaw, and the surgical treatment they require, may, I believe, be somewhat elucidated by the relation of these cases, and by the exhibition of the morbid specimens which have been removed.

CASE I.

Bony Cyst of the right side of the lower Jaw, with solid contents.—Amputation of the diseased portion of the Jaw, by the section of the bone near to its Symphysis, and Excision of the right Condyle from its socket.

Andrew M'Donnell, æt. 36, a fisherman, native of the County Wexford, of robust habit of body, was admitted into the Richmond Hospital, under my care, on the 19th of January, 1857. He had a considerable enlargement of the right side of the lower jaw, which here seemed expanded into an oblong tumor, about the size of a goose's egg. The swelling extended backwards from the angle

of the mouth to the back part of the ramus of the jaw. The cheek in the situation of the zygomatic arch and of the coronoid process, projected somewhat outwards towards the sub-maxillary fossa, which was also occupied by a hard swelling, evidently formed by the basis of the lower jaw, which had become increased in its breadth, and had extended itself downwards much below the level of its ordinary situation. A small but movable lymphatic gland could be felt in the sub-maxillary space. The cast taken of M'Donnell's face, when he was admitted into hospital, shows the external form the disease in this case assumed. On examining the tumor in the mouth the alveolar border of the jaw was seen expanded, so as to be nearly two inches in breadth; the three molar and second of the bicuspid teeth had disappeared, and scarcely a trace could be found on the gum of the place they had once occupied. Upon careful examination in the situation of the coronoid process and lower part of the temporal fossa, it appeared evident that this process was involved in the disease; at the same time, from the free motion of the jaw in its articular socket, it was equally clear that the surfaces of the articulation were not at all implicated. The tumor was remarkably elastic and yielding, yet it did not crackle under the pressure of the fingers, nor convey to the examiner the idea of fluid, but rather of some elastic material contained within a bony shell. The patient did not complain of any severe or darting pain whatever in the jaw, but simply of an aching sensation, which was only occasional. He did not wince, when firm pressure was made by the finger on the swollen part.

As to the origin of this disease, he said that about three years and a half ago, he got a severe knock on the right side of his lower jaw, the effect of a fall; some short time afterwards, while endeavouring to settle a dispute between two of his friends, one of them struck him with his clenched fist on the very same spot where a few days before he received the injury by the fall. About eight or ten days after this, he felt an aching in

the jaw, and then some stiffness in the motion of the joint, at the affected side; and when these symptoms had existed for about 15 months, he became alarmed, observing one day two small hard swellings on the gum. These gradually, from month to month, somewhat increased. The three molar teeth successively became loose and elevated above their ordinary level, so as to become annoying to him when the jaws closed; he on this account had them extracted. And although the alveoli seemed to close at once, yet he observed that when firm pressure was made on the swollen jaw, that there oozed out from the alveoli formerly occupied by the fangs of the teeth, a thin fluid which mixed with the saliva.

He thought that for the last six months the swelling seemed to enlarge more rapidly than it had done before.

A consultation of the surgeons of the hospital having been held on this case, it was agreed that there was only one measure to be thought of to relieve him, namely the amputation of all that portion of the lower jaw which was included in the disease, and that the condyle should be removed from its socket if it were found necessary. The healthy aspect of the man; the absence, in his case, of any fungous growth from the gum, or foetid discharge, and of all hard glandular enlargement; the sound appearance of the mucous membrane and skin covering the tumor; all gave us a favorable idea that the nature of the growing tumor was benign, yet it was not to be concealed that its progressive enlargement, if not arrested, must ultimately be the cause to him of a lingering death; all which having been explained to him, he made up his mind to submit to this severe and painful operation of amputation of the diseased portion of the bone. Unfortunately it was a case in which we were agreed chloroform could not be safely had recourse to, to lessen the sufferings of the patient during the operation.*

Operation.—The patient then, on the 4th of this month, February, 1857, was placed in a chair with a high back, and by his own request was well secured in it. The operation was begun by an incision from above, downwards through the whole substance of the lower lip, commencing a little nearer to the middle line than the right commissure of the lip (thus avoiding the commissure chiefly for reasons hereafter to be mentioned). The chain-saw was then introduced behind the arch of the lower jaw, and quickly passed through the bone, the section having been made through the line of the socket of the first bicuspid tooth, which had been extracted two days previously. The next incision through the skin was made parallel to, but a little above the basis of the jaw,

towards the angle of the bone at the right side, and this having been continued upwards, in front of, but parallel to, the back part of the ascending ramus, the skin, &c., forming a flap, was dissected off the masseter muscle, and the flap thrown up so as to expose fully the morbid mass of the tumor. The attachment of the masseter muscle was cut through, and the chain-saw was then had recourse to, and introduced behind the inside of the ramus, and the bone cut, across the basis of the neck of the condyle and the coronoid process. The portion of the lower jaw which constituted almost the whole of the disease, was thus isolated and included between the two sections made by the saw. The next proceeding to be undertaken was to disengage the diseased portion of the lower jaw from the surrounding soft parts. This was done by detaching any fibres of the masseter or internal pterygoid muscle which still adhered to the ramus of the jaw, and next by severing the connexion of the diseased portion of the bone from the muscles which were attached to the mylohyoid ridge, and connected it with the os hyoides. To effect this safely and expeditiously, the bone was firmly held in a strong forceps designed for such a purpose; and while Mr. Cusack rotated the bone as much as possible from within outwards, I ran the edge of the knife on the inside of the jaw, along the line of muscle attached to the mylohyoid ridge; and when this attachment of muscular fibres was severed, the bone was easily separated from the surrounding soft parts.

Numerous small arteries which had been necessarily divided now furnished a good deal of blood; some of these were at once secured, and the labial tied, before the last steps of the operation were proceeded with. Having now examined the state of the coronoid process, and of the condyle of the lower jaw, it was plain that these also were implicated, and must be taken away. The incision through the side of the face was then further extended a little upwards, towards the lobe of the ear. The capsule of the lower jaw exposed, we next endeavoured to draw down the coronoid process, which was expanded into a cell, but the altered bony structure gave way in the forceps, and although we were thus enabled to remove the coronoid process, we could not, as directed by other operators, by making use of it as a lever, disarticulate the condyle, and draw this forwards away from the glenoid cavity and vicinity of the internal maxillary artery. I was obliged, therefore, to open cautiously in front, the capsular ligament of the articulation; and I then introduced into the interior of the joint the handle of a tooth forceps, which was used as a lever, and by this means the condyle was safely pushed downwards from its place, and the external pterygoid was divided by a blunt-pointed bistoury, and the condyle was removed. Some delay now occurred in detaching some fragments of the coronoid process, which still remained attached to the temporal muscle.

* In this city we usually object to use chloroform when the patient is in the sitting posture, and this is the position we always place the patient in, whenever amputation of any portion of the jaw-bone is had recourse to.

There was, during this part of the operation also, some smart hæmorrhage, as the numerous small arteries were divided. When these were secured, and the bleeding ceased, I drew down the flap, and joined carefully the incision through the lip, and then by means of lint and sponge, the wound was dressed, and the patient put into bed.

During the day and night the patient had some hæmorrhage, but pressure by the fingers sufficed after a time to arrest it. During the night the patient was in rather an alarming state from constitutional irritation; his skin was clammy, his pulse small and weak, 132; he sighed frequently, and had a continued tendency to syncope, and was in an extreme state of mental and bodily depression. For these symptoms he was ordered brandy and wine freely during the night, with 15 drops of the solution of muriate of morphia, every second hour. After an hour he slept, and when the third opiate draught was taken, which was about half past two, he fell asleep, and continued so until morning. On awakening he stated he felt considerably better. His pulse was stronger; but he was still in a condition requiring the judicious use of stimulants. He was fed by means of a gum elastic tube fastened to the mouth of a drinking-cup.

It is now, February 21st, seventeen days since the day of the operation, and the man seems in perfect health; and one is truly surprised to see such a trifling degree of deformity resulting from removal of so large a portion of the lower jaw. The line of incision in the lip has joined by the first intention, and the greater part of the line, which ran parallel to the basis of the lower jaw and posterior margin, has also been nearly united. In a few days the cicatrices of the whole wound will, I doubt not, be complete.

In commenting on the *modus operandi* adopted in this case, some may think that the vertical incision through the red border of the lip might have been better omitted, as the chain-saw could have effected this section of the bone, without this preliminary step having been necessarily had recourse to; on the other hand it must be admitted that to expose fully the diseased mass we had to remove, appeared to be a great desideratum in such a case, which was best answered by the vertical incision through the substance of the lip, which permitted of the flap being thrown up fully on the cheek. By our having omitted the vertical incision above spoken of, it is said we might have avoided the deformity likely to result from the cicatrix of such a wound. To which, however, I would reply, that the union of such a wound as that above mentioned, need not of necessity be attended by deformity, if the incision through the lip be only made as it was here, not at the commissure of the lip, but at a little distance from it, nearer to the middle line. In the drawing which I lay before you, which is an exact representation of the patient's jaw now, but the seventeenth day since

the operation, and by your own examination of the patient himself, it may be seen that such an incision is not necessarily followed by any deformity whatsoever. The second incision through the skin, parallel to the lower margin of the inferior maxilla, should be made somewhat above the level of this margin, with the obvious view of rendering it easy to compress the labial artery as it turns round the bone, when we wish to include its cut extremity in a ligature. In two cases, from inattention to this simple rule, I saw much difficulty experienced by the Surgeon in securing the labial artery, when performing this operation, the incisions having been made unfortunately along the very margin of the lower jaw, the artery, as soon as cut, shrunk in behind the bone, and could not be compressed nor controlled, and bled freely while the Surgeon was vainly endeavouring to secure it by ligature, which, in consequence of the retraction of the cut artery behind the margin of the lower jaw, was only after much difficulty accomplished.

When the bone was sawn across in two places, the tumor, which was covered by some muscular structures, was next to be removed by the knife. But here let me impress this on your attention, that it is by no means a matter of indifference as to how this tumor is to be dissected out.

The best method has been pointed out by Mr. Cusack, and was adopted here, namely, to commence the final detachment of the bone, which had been already sawn across in two places, from the surrounding soft parts, by cutting through the mucous membrane of the mouth, upon the *inside* of the lower jaw-bone, where the mylo-hyoidean ridge exists. Here we know are attached all the muscles which retain this portion of bone still in connection with the os hyoides. While the operator thus cuts down on the inside of the lower jaw, his assistant is to seize the bone in a strong forceps constructed for such a purpose, and rotate it from within outwards, on its long axis, and thus it can be safely drawn out from its place, the operator always presenting the edge of his knife to the bone. This was the plan you saw adopted in the present instance.

When this portion of the distended shell of bone, including within it the great mass of the disease, was taken away, we next had to detach the condyle and coronoid process, which was an operation attended with some difficulty, but it was at length accomplished effectually. Some may object to the mode of proceeding adopted in this operation, so far as to the second section of the bone having been resorted to at all, it having been found afterwards necessary to disarticulate this side of the jaw-bone; but for my part I do not regret that this was the plan adopted, because I feel persuaded that if contented with this one division of the bone only, I had next proceeded to disarticulate the condyle from its socket, I should have then experienced the greatest difficulty in separating the attachment of the temporal and

external pterygoid muscle from the enlarged coronoid process and neck of the condyle, as well as in safely opening the capsular ligament of the joint.

The dissection which this disengagement required, "when the knife was continually used in the immediate neighbourhood of large and important arteries," was, it is plain, much more safely accomplished than it could have been done, had not the principal part of the morbid mass been previously removed.* If it had not, I feel persuaded I should have been embarrassed by the presence of a large tumor obscuring the recesses, from which I had to dissect out the above mentioned processes of the lower jaw. Indeed, I would say, that the same principle I am here advocating applies to the removal of any large tumor whose narrow and most adherent part is engaged in any deep recess; in such a case, although the great bulk of the tumor may have been disengaged from the surrounding parts, its narrow neck and most critical connexions have still to be managed; under such circumstances, I have seen the surgeon derive much advantage from retrenching the great external bulk of the swelling, which had obstructed his view of the deeper seated parts, and after this with much more facility and safety, was he enabled to disengage from its deeper connexions the neck of the tumor.

When we examine the portion of the lower jaw thus removed, we find it extends from the alveolar fossa of the second bicuspid tooth backward, and includes the coronoid process and condyle; the condyle we observe hollowed out into a bony shell, even to the interior of the head of the bone itself, but the articular surface is fortunately free from disease. The body of the lower jaw, we perceive, is expanded into a bony cyst or shell, which encloses within it a cartilaginous-like material, resembling that material we find composing the interior of these enlarged globular shaped fingers, affected with benign osteosarcoma, or, as some denominate the disease, spina ventosa.†

The case of bony cyst of the lower jaw which I have just detailed, I consider to be of the same nature as the above mentioned spina ventosa of the bones of the hand, or benign osteosarcoma. This is a disease which, if not early arrested, takes upon itself an unlimited growth, until softening of the contents of the bony cyst or sloughing take place, or the patient be carried off by hectic fever, and which in one case of this disease affecting the lower jaw I have seen to occur.

* Mr. Lawrence, in a similar case, adopted a similar mode of proceeding.—See *Lancet*, vol. i. 1834-5, p. 188.

† Boyer describes two species of spina ventosa, the one a strumous disease affecting the phalanges of the fingers in children, the other is the form of spina ventosa we allude to here; it is seen in adults, chiefly in the bones of the hand and fingers, which attain an enormous size.

Hereafter I shall endeavour to point out the diagnosis between malignant tumors which affect the lower jaw, and these benign bony cysts with solid or fluid contents; but for the present I will conclude by observing, that in cases of a decidedly malignant nature, the disease should not be interfered with by the surgeon, but when the disease is "benign," on the contrary, that amputation of the diseased part should be resorted to; and I will add, that no operation, however painful or severe, should be considered equivalent to the slow misery the unhappy patient has to endure, if his malady be left to take its miserable course, and it causes the death of its victim.

In the case which I have just related, the operation was necessarily tedious, painful, and severe, but I am happy to say, that so far as this (the seventeenth day after the operation) every thing is gone on in the most satisfactory manner, as all have had an opportunity of witnessing.

In my next lecture I shall lay before you a case of bony cyst of the lower jaw, with fluid contents, in which case amputation of a portion of the lower jaw was also successfully resorted to.

UTILITY OF THE POLARISCOPE IN CLINICAL INVESTIGATIONS.

By B. WILLS RICHARDSON,

Fellow and Member of the Court of Examiners of the Royal College of Surgeons.

A few months since Dr. McClinton transferred to my care a lady who had suffered repeatedly for a period of several years, from a variety of gastric symptoms, of which the most prominent were severe spasmodic pain in the epigastric and right hypochondriac regions, with extreme irritability of stomach. I may here bear testimony to the accurate view both Dr. Brunner (of Dundalk) and Dr. McClinton took of this lady's case, which was one involved in very great obscurity; and upon the true nature of which, opposite opinions had been expressed by eminent physicians, here and elsewhere. The diagnosis of the former gentlemen, has been recently verified by the discovery of a pretty large gallstone in an alvine evacuation, after one of her attacks of spasm. There can be little doubt that it was not the first passed, from the great number of years the patient has been suffering, as well as from the polished facettes of the one recently found in the dejection.

My object, at present, is to draw attention to some bodies which I found in the matters ejected from the stomach, during one of her most severe and violent attacks of spasm and vomiting, the nature of which bodies I could not have been certain of, without the aid of polarised light.

This lady's stomach was so excessively irritable for some days, that scarcely anything remained on it.

On one occasion she partook of some arrow-root (?) biscuit, which she fancied: but of which I was not, at the time, informed. When I subsequently examined the vomited fluid, in my investigation of the case, I discovered some large starch granules (*Fig. 1*); and with these, were

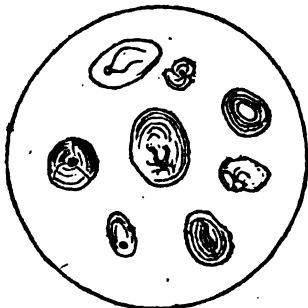


Fig. 1.

also seen, a few fissured collapsed-looking bodies (*Fig. 2*). What these were, was then to be ascertained; and I must acknowledge, I could not have determined their true character, only the polariscope revealed it. They turned out, likewise, to be starch granules: but in a semi-digested condition; the crosses were not so highly developed as in the more perfect grains, however, they were sufficient to enable me to distinguish them.

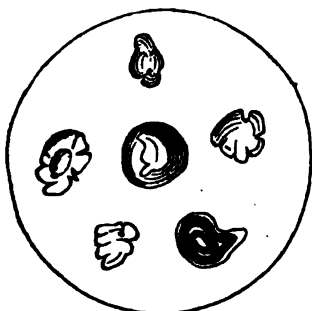


Fig. 2.

Another point was also revealed by this inquiry, namely, that the arrow-root (?) biscuit was chiefly composed of potato starch: for the greater number of the granules discerned, resembled, in every particular, the large grains of this farina. It would appear, therefore, that adulterated articles of food are to be found in Dublin as well as in London.

In conclusion, I do not wish to imply that there is anything novel in starch globules being found in vomited matters, or arrow-root being adulterated with potato starch. I merely record the observation, to illustrate the value of the polariscope in clinical investigation, as without its aid, in this case, I would have been quite unable to decide what was the nature of the bodies above alluded to, and I can well conceive their being mistaken for the so-called cancer-cells.

A CASE OF CONCUSSION OF THE SPINAL CORD, WITH CLINICAL OBSERVATIONS.

By JAS. STANNUS HUGHES, M.D., F.R.C.S.I.

Surgeon to the Jervis-street Hospital.

Concussion of the Spinal Cord, independent of fracture or luxation of the vertebræ, of which the following is an instructive example, has recently attracted more than usual attention, in consequence of its having become the leading question, in a medico-legal point of view, at a trial lately held in London, and at which some of the most eminent hospital surgeons of that metropolis were called on to give their testimony.

Case reported by Mr. COLAHAN, Resident Pupil to the Hospital.

L. Whelan, æt. 40, a strong healthy drayman, was admitted into Jervis-street Hospital on the 15th February, 1857.

History of the Case.—Whilst endeavouring to jump up on his dray, which was in rapid motion at the time, Whelan toppled over, coming to the ground on the back of his neck with great violence; he was immediately lifted up by the by-standers, and conveyed on a car to the hospital, as it was found that he had no power whatever over his legs. On examination after his reception into hospital, the following symptoms evinced themselves, viz.:—There was complete loss of motion, as well as of sensation, over both of his lower extremities, but he possessed perfect command over his bladder, having made water, of his own accord, soon after his admission; intellectual faculties unimpaired; pulse weak and quick; temperature of the legs and feet very low; no vomiting. A slight degree of swelling and redness existed at the seat of injury, corresponding to the fourth, fifth, and sixth cervical vertebræ; but no evidence of fracture of the vertebræ could be detected. After the patient had been for about an hour in bed, he began gradually to acquire some feeling in his lower extremities, together with a return of the power of motion; but according as he regained the motive power over his lower extremities, loss of power of motion, but not of sensation, over his hands and forearms, as gradually set in. In four hours after admission into hospital he had the perfect use of his lower extremities, but had completely lost the control over his forearms and hands.

Treatment.—Absolute rest in the recumbent posture enjoined. One dozen leeches were applied to the seat of injury, and two grains of calomel, together with one quarter of a grain of opium, were ordered to be given every fourth hour.

20th—Symptoms as before; mouth unaffected by the mercury. Continue the pills, and take 12 ozs. of blood, by cupping, from the back of the neck.

23rd.—The patient now enjoys more power

over his left hand and arm, but his right hand and forearm continue powerless; mouth slightly under the influence of mercury; but he has, during the night, been attacked with mercurial diarrhoea. Omit the pills; give chalk mixture and catechu, and rub half a drachm of mercurial ointment, night and morning, into the axillæ; apply a blister to the back of the neck, and dress the surface afterwards with Albespeyre's issue paper (No. 2).

March 4th.—Power over left hand and forearm improved, but the right hand and forearm remain almost perfectly paralysed; mouth slightly affected. Ordered half a grain of the sesque iodide of mercury, in the form of pill, three times in the day. Electro-galvanism was directed to be applied, daily, from the region of the neck to the right hand and fingers, beginning at a low power, and gradually increasing it in strength.

12th.—A progressive amendment has taken place since last report. The patient has regained complete power over his left hand, and is daily regaining the use of his right one. The electro-galvanism has been applied each day, as directed. The iodide of mercury was withdrawn this day, mercurial fœtor and insalivation, being present.

April 2nd.—The patient is now so far improved, that he can tightly grasp a small object with both his hands, and he feels so well, in every respect, that he is anxious to return home; but has been prevailed on to remain in hospital for a few days longer.

REMARKS.

Concussion of the spinal cord, independent of fracture or luxation of the vertebræ, may present varieties, both as to the extent, intensity, and duration of its symptoms; thus it may give rise to but a partial and transient impairment of the powers of motion or sensation, or of both, to parts below the seat of injury; it may be followed by complete and permanent destruction of motive power, and of sensation, of either one or more of the extremities; or it may, on the other hand, when affecting the cord above the origin of the respiratory nerves, prove instantaneously fatal. Sometimes, in concussion of the spinal cord, death ensues at a remote period, from bed-sores and sloughing; at other times, the patient is carried off by chronic inflammation of the bladder and kidneys.

Concussion of the spinal cord, independent of fracture or luxation of the vertebræ, is not unfrequently accompanied by more or less compression of the spinal cord, the consequence of either effusion of blood, or of lymph, or of both (which was probably the case in the man at present in the hospital) a point of importance, with a view to the treatment of these injuries.

The loss of power, in a case of concussion of the spinal cord, will, to a great extent, depend on the part of the cord injured. Thus, for instance, in the case of Whelan, at present under our observation, in which the violence was applied to the re-

gion of the neck, but below the origin of the respiratory nerves, the patient was immediately affected with loss of power and sensation over the lower extremities, and, soon afterwards, by paralysis of his forearms and hands; but it is an interesting fact, and one of course much in his favour, that he never lost control over his urinary bladder.

About two years ago, we had, as many of you no doubt recollect, a Prussian sailor, Kramoset by name, under our care in this hospital, who, having on a long voyage at sea, fallen in a gale of wind from the main-yard arm of his ship to the deck, on his back, was instantly seized by paralysis and loss of sensation of the lower extremities, as well as by loss of power over his bladder. In the Prussian's case, the injury was chiefly confined to the lumbar portion of the spine, where he was struck, in his fall, by a projecting part of the deck. Whether in his case there had been a fracture of one of the vertebræ, was a matter of speculation, there being apparently the *slightest possible* projection of one of the lumbar spinous processes. We kept the poor fellow for some months in the hospital, at the expiration of which time we sent him to his own country, through means of the Prussian consul, having regained perfect power over his urinary bladder, and somewhat improved in his other symptoms, but not materially so, with a view to his ultimate recovery.

It is very important to hold in mind, that a severe shock communicated to the spinal column, may be followed by symptoms very different indeed from those of concussion or compression of the spinal cord, in proof of which I need only mention, that about two years or so ago, I was asked by Dr. Kavanagh, junior, of Kingstown, to see a sailor boy, with him, who had fallen on his head and spine to the deck, from a temporary gallery, which had been erected round the funnel of a steamship, and who, as the result of the accident, was, at the time I visited him in consultation, labouring under all the well-marked symptoms of cerebro-spinal arachnitis.

As to the diagnosis of concussion of the spinal cord, *lesions of motion or of sensation, or of both, to a greater or lesser extent, and for a longer or shorter period, over one or more of the extremities, supervening instantaneously on shocks communicated to the spinal column, are the symptoms that are characteristic of concussion of the spinal cord; and where these are completely absent, true concussion of the spinal cord does not, according to the modern acceptation of the term, exist.* Myelitis, or spinal arachnitis, which are very different in their symptoms, and which may result from violence inflicted on the spinal column, must, therefore, not be mistaken for concussion of the spinal cord.

Now, with regard to the pathology of concussion of the spinal cord, when opportunities have been afforded of examining the medulla spinalis, immediately, or soon after the receipt of the injury, a highly vascular state of the cord has

been detected; in some cases, the cord exhibiting, on division, a somewhat reddish hue; in others assuming a yellowish or preternaturally white appearance; whilst in others again, apoplectic clots have been found in the substance, or on the surface of the cord; whereas, in many of the instances on record, no morbid appearances whatever presented themselves to the eye either in or about the spinal cord or its membranes. Thus, Frank mentions four cases of concussion of the spine, in not one of which could any morbid appearance be detected, either in the vertebrae, or in or on the spinal cord.

We cannot be too cautious in delivering our prognosis in a case of concussion of the spinal cord, inasmuch as it is by no means at all easy to foretell in what manner a case is likely to terminate; but we should, as a general rule, be chiefly guided in forming our opinion as to the likely results, by the following considerations, viz.: the seat of injury, the extent of nervous lesion, and the condition of the urinary bladder. The most unpromising cases do, however, sometimes recover. A man may, on the other hand, apparently completely recover from the results of concussion of the spinal cord, and yet, after a longer or shorter lapse of time, become the subject of ramollissement of the medulla spinalis, as a remote consequence of the injury.

The chief indications in the treatment of a case of concussion of the spinal cord are, absolute rest in the horizontal position; the use of the catheter, when necessary; depletion, general or local, according to circumstances; the administration of mercury, so as to bring the system rapidly under its influence; the avoidance of bed-sores; and the application of electro-galvanism, should such be deemed requisite.

Absolute rest, in the recumbent position, is best carried out in injuries of the spinal column, by the use of one of Earle's beds, by which means the patient need not abandon the horizontal position, or move his spine, even during the action of the bowels.

With regard to the exhibition of mercury in concussion of the spinal cord, many prefer calomel; others the iodides. In Whelan's case, we kept up the mercurial action for some days, by the administration of half-grain doses of the sesquioxide of mercury, as it has the character of rapidly rousing the absorbents in removing extravasated blood, or lymph, or both, when effused.

In concussion of the spinal cord, counter irritation frequently proves useful; and electro-galvanism may, if used at the proper period, as in Whelan's case, act most beneficially.

Bed-sores, which are with much difficulty kept off in concussion of the spinal cord, where there is persistent paralysis of the lower extremities, are best avoided by the use of suitable pillows, air cushions, or the water bed; or by placing the patient on partially inflated ox bladders. When

bed-sores threaten, the surface should be painted over with solutions of gun cotton or gutta percha in chloroform or ether.

In conclusion, it is scarcely necessary to say, that the greatest attention should be paid to the condition of the urinary bladder, in all cases of concussion of the spinal chord; and that, if necessary, the urine should be drawn off by means of a catheter, as often as may be required.

ON THE SPOTS OBSERVED IN THE PROGRESS OF FEVER,

ESPECIALLY CONSIDERED AS A MEANS OF DIAGNOSIS.

By HENRY KENNEDY, A.B., M.B.,

Censor of the Royal and Queen's College of Physicians;
Physician Extra to Sir P. Dun's Hospital.

(Read before the Medical Association of the College
of Physicians of Dublin.)

Of the several symptoms of fever which have attracted a special notice, the spots which appear in its progress have not received the least. In fact, more attention has been given to them than probably to any other single symptom. Their presence, numbers, and characters, have each in turn given names to particular forms of fever. Many questions connected with these spots are really of much moment; and it has often appeared to me that views prevail with regard to them which facts do not warrant. As an example of what I mean, I would mention the very prevalent idea that the presence or absence of spots at once marks the kind of fever present. Now, this I consider quite incorrect; I have often observed cases of fever to come from the same room—often from the same bed—and yet some of them only to present spots. Or a husband and wife are attacked with fever, and the one is spotted, the other not. Some time since, three brothers, adults, were admitted into Cork-street Hospital, under the care of Dr. George Kennedy. They lived together, and were admitted within two days of each other; they had all heavy fever, but one only was spotted. Will it be maintained that those men suffered from different kinds of fever, merely because one was spotted and the others not? When we see a measly eruption on one member of a family, and a petechial rash on another, and these two come from the same room, are we justified in considering their fevers as different? Will any analogy bear out this view? Some time back, I saw, with my friend Dr. Denham, five members of the same family labouring under scarlatina; not one of these had the same form of disease. I presume few would maintain that the disease was due to a different poison in each instance. Yet when precisely a similar occurrence takes place in our ordinary fevers, it is considered by many

to be caused by a variety in the poison; and the presence of spots, above all, makes many look on the disease as something very specific. My own strong conviction is, that all such differences as those alluded to are due, either to the intensity of the poison, or the state of the constitution at the time being; or any cause rather than a difference of the poison. No other explanation, as it appears to me, will account for all the facts of the case; and I think it is time that the opinions spoken of should be abandoned: as, in the first instance, not being supported by facts; and, secondly, as being quite capable of leading to erroneous views of treatment. The varied types of fever are, I believe, due to entirely different causes than specific poisons for each; but a consideration of these points does not come within the scope of the present remarks.

A second point which I would notice before entering on the more immediate subject of this paper is, as to whether there is anything of a specific character in the fever of this country. In 1847-48 the expression "Irish fever," was to be found through all the public papers of our neighbours on the other side of the channel. It became almost a fashionable expression; and the words themselves were the means of conveying more than an insinuation that the epidemic fever which then prevailed began in Ireland, and was carried by our people in every direction. Some even of our professional brethren, especially in Scotland, took up this view of the matter. Now I freely admit that sickness may be carried from this side of the channel to the other, and *vice versa*; but whilst admitting this, there are two points which are not to be lost sight of. First, there is no fever peculiar to this country, as distinguished from what is seen in England and Scotland. There is no "Irish fever," properly so called; and on this point I appeal to the descriptions of the disease published by English physicians themselves.* But secondly, and this is the important point to notice—there exists the clearest evidence to show, that before we had epidemic fever here in 1847-48, the disease had increased much in England. Nor is this a solitary instance in point. There is a great law affecting all the more widespread epidemics, and showing that their course across the globe is from east to west, or from south-east to north-west.

At a certain period of some cases of fever, it is well known that spots make their appearance. This is usually from the 6th to the 9th day of the disease; but on this point there are great differences. I think it may be stated that they will be

occasionally seen as early as the third day, reckoning from the period of the rigor. There are difficulties, however, in determining this; for it by no means follows that the patient is not ill before the rigor. Still, some of the cases I have seen were inquired into as minutely as was possible, and the spots did appear then on the third day. On the other hand they are often much later than what is usual in making their appearance. Thus I have seen them as late as the twentieth day; and very critical cases all such in general were. But there is another and more important point still to be noticed as to the time of their appearance. I allude to those cases where the fever is made up of two parts, with an interval between. Here they may be absent in the first and present in the second, and *vice versa*; though the last is not as common as the first. I have notes of more than one case where the individual passed through three distinct fevers before leaving the hospital; yet it was only in one of the series that spots appeared. And alluding to the question of any individual ever having spotted fever a second time, I may state that it has not come under my notice; though my friend Dr. George Kennedy has seen it, but very rarely.

There is still one other point worthy of notice in connexion with the period when spots appear; I mean cases where we would have every reason to suppose that they would appear at the same time. As an example I may mention that not long since two sisters, both grown women, and remarkable for their great stature, were admitted into Cork-street Hospital, labouring under heavy fever. They each exhibited spots; yet one of them was spotted four clear days before the other. The fact is of interest, as showing how the constitution will modify the eruption; for there was no other explanation, which in this particular instance, would account for it. These two sisters had sickened at the same time. Precisely an analogous circumstance has come under my notice in scarlatina; that is, the period at which the rash appears will vary by three or four days, though children of the same family have sickened together.

The spots of fever may exhibit themselves, as is well known, over the whole body. But in general they are more limited than this. Where they first appear I will not take on myself to determine; though I believe they will be as early seen about the pectoral muscles as anywhere else. There are some modifications of them, however, having relation to their site, which appear to me worthy of notice. Thus it is by no means uncommon to see them exclusively confined to the upper part of the body. Not one will be seen on

* Petechial fever is certainly not the peculiar disease of this country. I have never seen the majority of cases, at any one period, present spots of any kind; nor indeed has there been any approach to this. One spotted case in every five, I have seen; but even this is rare. In 1847-48, cases attended by spots were very exceptional.

* It is the last of the series which exhibits the spots in these instances. In one case of this kind I find it was the fourth attack, and the spots then were of the character of measles eruption.

the lower limbs.* Again, I have seen them confined, and in the most marked manner, to the joints. Not long since, a young man of 18 was admitted into Cork-street Hospital, under Dr. George Kennedy. He was very seriously ill, his fever being marked by prolonged vomiting, of a character such as my friend, Dr. Fraser, has drawn attention to. His pulse rapid and very weak. Great distress. In the course of this illness, his elbows and knees exhibited spots, each in number probably of from 40 to 50. † I could not detect a single spot anywhere else. Their character partook of a mixture of purpura and petechiæ, and they appeared to me to be slightly raised. The case recovered. Dr. Kennedy informs me he has seen several similar instances. I have now seen many cases where the spots were first visible on the backs of the wrists; and usually they have here been of a bright-red colour. I have seen also instances where they were located in patches, as it were, and these symmetrical, on either pectoral muscle. In one instance well marked spots, of a bright hue, came out over the whole front of the throat and neck, and the inside of either elbow, nor could I detect any elsewhere.

Lastly, I have seen spots on the face and forehead; and I mention this particularly, because some observers have asserted that they are never seen here. This is certainly incorrect. I have notes of some eight cases, which may now be increased to eleven, where there could be no question of the fact. Last autumn, a man named Speight passed through a severe attack of acute rheumatism. He had recovered so far as to have left hospital a fortnight, when he was re-admitted labouring under one of the worst forms of fever. He was very generally and densely spotted; and on the thirteenth day of the attack, a crop of petechiæ was as distinct on the face and forehead, as on any other part of the body. This case recovered. ‡ The way then to speak of the fact is, as being very rare, in comparison with the number of cases which exhibit spots elsewhere; but to say it does not occur at all is going farther than facts will justify. I think I have seen spots on the conjunctivæ, or at least what might be described as a mottled state of this membrane; and instances are not uncommon where a rupture of a blood-vessel, or an exudation of blood, has caused a distinct ecchymosis—I mean of course in fever. Is it straining the fact too far to suppose that such a spot is but an ordinary petechia in an unusual place? I have never seen the occurrence in fever except in conjunction with spots elsewhere.

The character of the spots of fever has long attracted notice, and some of them unquestionably deserve a special attention; but for reasons, some of which have been already given, while com-

mencing these remarks, it appears to me too much stress has been laid on this point. Thus the bright, well-defined, lenticular spots are, I believe, constantly spoken of as being different from what are called genuine petechiæ. Now I cannot but think this is an erroneous way of considering the matter; and for the simple reason that they may be very often seen existing together, at the same time, and on the one patient. In this way we may find the bright, well-defined spots on the arms, and the petechiæ on the body.* Of such I have seen several cases. Or again, we may see one member of a family presenting the bright spots and another the petechiæ; yet both have come from the same room. Speaking of the two kinds of eruption reminds me that some of the older authors on fever have described two crops as occurring in the one patient. This I have seen in the most marked form, not only in fever, but also in scarlatina. And in truth the analogies which the exanthemata hold, one with the other, does not appear to me to have received that consideration which they deserve. Who has not seen cases of scarlatina presenting on the surface different hues of eruption, I mean at the same time? Purpuric spots, great patches of redness of different hues, universal redness of the entire surface, and above all, spots, not possible to distinguish from what are called genuine petechiæ, may be mixed up together in the one patient; to say nothing of the varieties which the disease so often presents when going through an entire family. Now under such circumstances no one ever dreams of saying there are different poisons, according to the varied hues of the rash; yet when exactly analogous facts occur in common fever, some inexplicable necessity seems to arise for drawing distinctions where there are in reality none, and refining to a degree which, it appears to me, facts do not justify. That much valuable information—more especially as regards prognosis—may be derived from close observation of the eruption which common fever exhibits, is readily admitted; such as the brighter or darker hue which it presents; the greater or lesser size of the spots; their early or their late appearance, &c. But these points, let it be observed, are quite beside the question of whether the varieties which we see in the rash of common fever be due to separate and specific poisons, or only to one; and whether it be not more consistent with facts to attribute them rather to the temperament of the patient, the state of his general health at the time being, his age, &c., rather than to this or that poison. And this leads on to a question in direct connexion with this part of the subject, about which more has been written than on any other; that is, the distinction which exists, or is said to exist, in the rash of typhus, as dis-

* I have seen them, too, nearly exclusively confined to the abdomen; but not absolutely.

† Louis, I find, gives one instance where spots were visible on the face.

* At this very time (January, 1857) I have a patient in fever in Dun's Hospital, who exhibits bright spots on the wrists and arms, and well-marked and dark petechiæ on the chest. She is a girl of 19.

tinguished from the fever attended by local lesion in the small intestine, and known as typhoid fever.* On this point, I believe, authors have been too precise, and have not made allowance for the possibility of deviations, which here, as indeed in every other point connected with fever, are liable to arise. Thus, from the perusal of the most recent works on the subject, one would suppose that typhoid fever could not exist without the presence of bright lenticular spots, few in number, and disappearing long before the fever ends. Now I do not deny that this state generally obtains; but I do say that it is by no means constant.† I have observed cases from the very beginning to the death of the patient, and to a *post mortem* examination, disclosing ulcerations of the small intestine; and yet from first to last no spots whatever were visible. And the opposite of this, again, is still more common. I have notes of a number of cases where the spots had all the characteristics, as to time, number, size, and disappearance, and yet the cases had no other symptom whatever of enteric fever, and in reality were not the disease at all.‡ With such facts in view, it appears to me great caution should be used in pronouncing any spots as diagnostic of this or that kind of fever; or at least of giving them more weight than any other single symptom of the disease is entitled to. It may be observed in passing, that the number of cases in which bright, well-defined spots, and few in number, have come under my notice, within the last three months, has been truly remarkable. I recollect nothing like it in previous years. Is it necessary to add that these spots were not diagnostic of enteric fever at all.

It has been already stated that much valuable aid, in a prognostic point of view, may be derived from the spots which appear in fever; and I believe it is generally admitted that the darker and larger they are the more serious is the case. In my own experience this has been so; and the worst cases I have ever seen have been attended with few spots of a large size, and confined very generally to the region of the clavicles and groins, sometimes running down the inner side of the thighs.‡ A much rarer appearance than this I

* So far back as 1837, I published, in the *Dublin Medical Journal*, a paper on this very subject. It contained, I believe, every point which has since been advanced as a means of diagnosis between typhus and typhoid fever. The paper has been acknowledged in America, but ignored in London, where much labour has been spent by Dr. Jenner in determining what was known 20 years previously.

† I have also witnessed cases where all the symptoms were those of enteric fever, except that the spots were dark on the chest; and in the inguinal regions, assumed the character of purpura. I find notes, also, of one case where the spots were genuine petechiæ, and where ulceration of the bowels was found.

‡ It is worthy of notice that these large and dark petechiæ, or by whatever name they are called, are not confined to typhus, but may be seen in puerperal fever, and in some cases of malignant scarlatina.

have also observed, and if it be possible shewing a more malignant form of disease; I mean where the subcutaneous veins of both the upper and lower extremities have allowed a bloody serum to exude, which is quite visible through the skin. With this state I have found in the pleura, and also the pericardium, and on the surface of the brain, serum poured out which was likewise tinged deeply with blood. In one instance I found a large effusion of blood under the pleura covering the left lung.

Of the supervention of fever in persons afflicted at the time with chronic diseases, I presume all who hear me have seen examples. I mean fever attended with spots. Thus I have met several examples of persons who were hemiplegic, and in this state were attacked with petechial fever; and again, others who laboured under chronic bronchitis and asthma. Cases of phthisis, too, have come under my notice in a similar way; but the fever in these instances has been rarely attended with spots. This latter, however, I have witnessed, the rash being most copious. Cases of chronic affections of the eyes, ulcers of the legs, and chronic diseases of the skin, are of very common occurrence in union with spotted fever. Lastly, I have witnessed fever, and in its very worst forms, with both primary and secondary syphilis. It is worthy of notice how little any of these affections are altered by the fever. Speaking generally of them, they are certainly not made worse; though such might be expected; at least of some of them. I have, however, seen cases of disease of the skin, where it was got rid of, after the fever. But usually they go on as they did before. In my own experience it is only a state of derangement of the general health, and not any specific affection, which is likely to be bettered by spotted fever.

It may possibly not be out of place to put the above into a series of propositions.

- 1.—That there is no form of fever peculiar to Ireland.
- 2.—That in 1847-48, the epidemic which then prevailed in Ireland had existed in England for months previously.
- 3.—That this epidemic, like all other great ones, travelled from east to west.
- 4.—That the idea of different poisons, as a cause of the several varieties of rash, does not appear to be borne out by facts.
- 5.—That the analogies derived from the study of the exanthemata are opposed to the idea of there being more than one poison.
- 6.—That red and dark petechiæ may co-exist in the same patient, at the same time.
- 7.—That either may precode the other. That some members of a family may exhibit spots—others not; all being ill at the same time.
- 8.—That petechiæ may be almost exclusively confined to the abdomen, or to the upper half of the body; or exhibited in groups on the pectoral

muscles, the front of the larynx, or strictly confined to the knees or elbows.

9.—That they may be seen occasionally, but unequivocally, displayed on the face, and possibly on the conjunctivæ.

10.—That bright lenticular spots, and few in number, are of frequent occurrence, without any other symptoms of enteric fever.

11.—That fever without intestinal lesion may exist without any spots whatever.

12.—That the same lesion may exist with dark petechiæ.

13.—That petechial fever may run its course in patients affected with such diseases as hemiplegia, phthisis, syphilis, &c.

14.—That large, dark petechiæ are not confined to typhus, but may be seen in puerperal fever, and cases of malignant scarlatina.

15.—That in some very bad forms of fever, the veins allow the blood to exude in a very striking way; and together with this, serum, deeply tinged with blood, may be found poured out in the serous cavities.

CASE OF CARDIAC AND HEPATIC DISEASE,

WITH AN ACCOUNT OF THE POST MORTEM EXAMINATION.

By Dr. M'GEE,

President of the Belfast Clinical and Pathological Society.

(Communicated to the Society, February 28th.)

On the 10th of June I was called to visit Mr. —, aged 22, said to be ill with cholera.

His parents report, that of late he has had morning nausea and loss of appetite, that he could not walk quickly nor use much exertion, especially after meals, without inconvenience, and that standing or stooping gave him pain or weakness in his back. For the last three or four years he has indulged in the free use of ardent spirits.

On the 7th June he was observed to be looking ill, but he would not admit that he had any ailment.

His family have no knowledge as to where or how he passed the night of the 7th. He returned home at noon on the 8th, and went to bed, being too unwell to attend to business.

He complained that his bowels were much relaxed, to which, he stated, he had been subject at intervals, during the preceding seven or eight weeks, and he took a few drops of tinct. morphia, from which he had before found relief.

It was observed that his countenance and lips were pallid, and that he had much thirst, with total loss of appetite.

On the afternoon of June 9, the medical attendant of the family visited and prescribed for the patient, and remained with him all night. His report is as follows:—

“About 7 p.m. of the 9th instant, I was called; for the first time, to visit Mr. —, who I understood was a free liver. He had been for the twelve hours previous affected with severe and frequent vomiting and purging, attended with slight cramps of limbs; pulse 120, weak; tongue slightly furred. On palpation of abdomen there was no perceptible enlargement of any viscus; but slight tenderness on pressure over the epigastrium; the temperature of the skin of the body was natural; the feet rather cold. I ordered a sinapism over the epigastrium, and acetate of lead and opium every hour for the first three doses, and afterwards every two hours, till the evacuations would be checked. This had the effect of checking the frequency of the evacuations, but they never entirely ceased.”

On my first visit, in consultation with Dr. S., at 1 p.m. of the 10th, I found the patient perfectly sensible, his countenance anxious, pallid, but not yellow; his eyes sunken; conjunctivæ, not injected, and free from bilious tinge; lips pale; his tongue slightly furred, creamy, without red tip or edges, its heat natural; voice strong and unchanged in its character; respiration variable, hurried by exertion of moving or speaking, but not laborious; skin warmer than natural, and moist; extremities warm; pulse from 110—130, very irregular and unequal, at times firm and full, again small and compressible, occasionally intermitting; no hardness nor very prominent swelling in the hypochondria; dulness on percussion over the upper part of the abdomen and lower region of the thorax, with almost tympanitic resonance over the apex of the lung on both sides. The stethoscope gave bronchial respiration at both infraclavicular regions; heart displaced, being abnormally high and to the left; there was a distinct double impulse, or rather a reduplication of the second sound, with regurgitant murmur after both systole and diastole; no friction sound; no œdema of face, nor anasarca of feet or ankles. His friends, however, say, that of late there has been considerable puffiness of the face, but that during the last few days it had disappeared.

The patient complains of some pain or discomfort in the left side of the chest, which had been more severe two days ago; moderate pressure over the epigastric and right hypochondriac regions gives pain; much thirst; stomach irritable; bowels relaxed. Yesterday and last night, “slight pain, but not exactly cramp,” in his lower limbs; says he has for some time had morning cough with expectoration.

It was agreed that he should take, every third hour, calomel and opium, that a blister should be applied over the epigastrium immediately, and an opiate given whenever the state of the bowels required it.

Soon after our visit he vomited about six ounces of serous-like fluid, containing flocculi, and tinged with bile, and he passed four or five ounces of very

natural looking urine. Bowels were moved, the evacuation trifling in quantity, consisted of yellowish green serum.

His pulse, when I left the room, was moderately firm, and his voice strong. In one or two minutes after, his servant recalled me hastily, and on reaching the patient's room I found the heart had ceased to beat, and after a few gasping inspirations he died without a struggle.

Post mortem examination.—On opening the chest, 20 hours after death, there was no effusion, the lungs were free from adhesion, crepitating freely, and healthy looking, with the exceptions that at their dorsal aspect they were congested, perhaps owing to gravitation from position, and that both lungs were much compressed and pushed upward by a greatly enlarged liver.

The heart was placed unusually high and to the left, its apex not below the middle or inferior margin of the fifth rib. On opening the pericardial sac, it was free from adhesions, and contained not more than two oz. of reddish serum, without flocculi.

At the centre of the anterior septum of the heart, (underneath the pericardium,) was a very distinct milk spot, $1\frac{1}{2}$ inch by 1 inch, depressed rather than elevated, and very slightly corrugated; no other evidence of pericardial disease; coronary veins turgid.

Heart abnormally large; left ventricle empty, and feeling firm and solid; right ventricle loose and flaccid.

On cutting through the aorta a fibrinous polypus, or rather polypoid concretion, was observed within it, issuing from the ventricle and passing into the innominata and subclavian and carotid arteries. A similar but larger fibrinous concretion was observed in the pulmonary arteries, issuing from the right auricle, and passing through the ventricle.

On cutting through the walls of the ventricles the muscular fibre of the left was unusually firm, and both were of a darkish red hue.

The endocardium was deep red, in patches, especially about the region of the semilunar valves.

On the ventricular surface of the semilunar valves, aortic and pulmonary, was found a deposit of coagulable lymph of recent formation, and easily removed by the finger. The left auricle and ventricle were empty; the right auricle and ventricle flaccid, and nearly filled with black semi-coagulated blood; all the cavities were enlarged, the right ventricle especially so; its walls at centre $7\frac{1}{2}$ to 8 lines thick; left ventricle 10 lines.

Of the fibrinous substances above mentioned, that from the aorta, having been incautiously removed before testing the efficiency of the aortic valves, those valves were found to act perfectly. The place of attachment of the polypus to the mitral valves within the auricle, was shewn by a bloody mark or root. On the right side, the polypus being in situ, the pulmonary semilunar

valves were found to be totally inefficient, until the polypus was withdrawn, and then those valves were as efficient as the aortic valves.

The fibrinous concretions or polypi when removed, were whitish-grey, elastic, with a very few small spots or streaks of blood, and had no appearance of layers or filaments; but they became so after a few days, and shrunk much. That from the right side was much the longer, with a broad attachment and interlaced root appearing at its origin from the tricuspid valves, almost sanguineous. The valves were nowhere adherent to each other, nor was there any rupture of the cordæ tendinæ, columnæ carnæ, or musculi papillares.

The stomach was pressed back and covered by the left lobe of the liver, was little larger than natural, and shewed no saccular dilatation, excepting at its cardiac extremity, where it was slightly pouched. Its peritoneal covering and muscular tissue were normal;—veins at the great curvature much congested.

On slitting it up, it was found to contain a small quantity of a thick, ash-grey fluid, with flocculi; two or three large ecchymosed patches near its cardiac end; and numerous red stellated spots, not tumid nor elevated, on other parts. In some places near the pylorus, the mucous membrane was thickened; in other places, and especially along certain elevated rugæ on its anterior aspect, between the greater and lesser curvatures, the mucous membrane was softened, in spots disorganized, or entirely removed; the ulcer-like spots being covered by a greyish-white exudation or deposit, easily removable. The sub-mucous cellular tissue very little changed.

The liver was very much hypertrophied, more especially in its vertical and transverse diameters; and by its size and position must have materially interfered with the due performance of the functions of the lungs and heart. We had no opportunity of weighing it; but, as by measurement, it displaced 10 imperial pints of water, its weight was estimated at not less than 14lbs.

The right lobe was tumid, semiglobular, and reached in front as high as the inferior margin of the third rib, pushing the heart to the left of the mesial line. The left lobe over-lapped the stomach, and extended even beyond its cardiac extremity, pressing the spleen far back, and trenching somewhat on the left cavity of the thorax.

The surface of the liver was tense, smooth, and shining; when cut into, its colour and firmness were natural, and it did not appear to have undergone acute disease. There was venous congestion, not hepatitis. The tubuli were gorged with bile, and the handling the liver left on the fingers and palms of the hands, an orange-yellow stain, not removable for many hours. A portion of the liver under the microscope showed fatty degeneration. The gall-bladder, not larger than such a liver demanded, contained $1\frac{1}{2}$ oz. of bile.

On reviewing this case, one is struck by the remarkable absence of complaint on the part of the patient, in the early stage; and by the extreme rapidity with which it hurried on to its fatal termination. No opportunity was afforded of making a second examination before death; but serious heart disease especially involving the valves, was clearly diagnosed.

If we may inquire into the rationale of symptoms, as well *absent* as present, it seems strange that the tongue gave no evidence of the gastritis which had existed; why the hypertrophy and congestion of the liver were not accompanied by œdema or anasarca, or by a jaundice tint of the conjunctivæ; or why the vomiting and purging did not call forth more of the symptoms of gastro-enterite during life.

The only detail of symptoms evidencing inconvenience from the bulk of the liver, was the statement of a friend, who, about a week before, had observed the patient, when stepping off the curbstone on the street, throw his right arm across the stomach, as if to give support. *Perhaps*, also, the difficulty of walking rapidly, after a full meal, is in some degree referable to the state of the liver.

Though I believe the immediate cause of death to have been the interference with the heart's action caused by the fibrinous concretions; and Hasse says such are often the immediate cause of death; yet from the previous history of the patient, I suppose the liver to have been the seat of the first serious disease. It may be urged that the fibrinous concretions were produced by or during the agony, or immediately after death, as is often the case in stout muscular patients; or again, that they may have been the result of some cause tending to produce coagulation of the blood, as absorbed pus, phlebitis, or softened tubercle; but no such causes existed here, nor was there any agony, and the concretions differed much from the soft amber-coloured coagula which are found occasionally filling the ventricles. I believe the concretions to have been the result of endocardial inflammation, and to have permitted the regurgitation indicated by the stethoscope; for though it has been asserted that there is always some reflux permitted from the pulmonary arteries, yet *after* the removal of the polypi, the semilunar valves were found to be efficient.

The amount of serum found in the pericardial sac cannot have had much effect in producing the rapidly fatal result; for though Rokitanaky considers half-an-ounce of serum a normal quantity, other pathologists believe that a much larger quantity may be present without it being deemed unusual.

As regards the reddening seen on the endocardium, it is often observed, produced by imbibition &c., independent of endocarditis; but in this case it could not be referred to imbibition, as it was observed in the left ventricle, which was found

empty; neither could it have had as its cause low or typhoid pneumonia; but it has also been observed in those dying from the abuse of ardent spirits. If, then, we consider the carbonized state of the blood from the pressure of the liver on the lungs, and the consequent congestion, we had both causes here present, operating powerfully; yet from a review of all the evidence on the case, I am led to refer the reddening to endocarditis.

Were the appearances observed in the stomach the evidence or the results of an acute attack or exacerbation of mucous gastritis or gastric catarrh, induced by hyperæmia, whether *active* from continued stimulation, or mechanical from hypertrophied liver; or did both these causes, as I believe, operate?

Drunkards, we know, are prone to gastric catarrh; and while the vomiting is spasmodic, as in cholera, and in some forms of yellow fever, the affection often extends to the entire intestinal canal. The cause of the hypertrophy of the liver is too evident to require comment.

In the *Medical Times and Gazette* of May 8, 1852, Mr. Richardson gives a report of the case of a girl of 14, on whom he had been in attendance for sixteen days, for cardiac disease. On the morning of the sixteenth day, she had a sudden sensation of faintness. She rallied; but same evening, raising herself for drink, she complained of great weakness, and instantly expired.

"The *post mortem* examination shewed, among other evidence of disease, dilatation of all the cardiac cavities and vessels; and also three fibrinous deposits, weighing collectively above 200 grains; one *filling* the right auricle in the pulmonary artery, at its root, in the left ventricle, so entwined with the mitral valves, that the faces of the valves were brought close and bound together by it. These concretions were true and direct depositions from the blood, and not from exudation. There was no trace of endocardial lesion. It was clear they were formed during life, and while the blood was circulating. The heart might be said to have *churned* the blood, which in passing left portions of its surplus fibrine on the elevated structures. The heart was choked on one side, its valvular apparatus prevented free play on the other, and death was the necessary result."

BERBERINE.—In the 'Hygeia,' M. Altin gives an account of berberine, prepared from the bark of the root of the wild berries growing near Stockholm. When after attacks of cholera a mucous colourless diarrhoea continues, and the urinary secretion is not re-established, the berberine remedies these two conditions. It exerts remarkable effects in the different cases of gastricismus, accompanied by disturbed action of the liver, and becoming severe and obstinate under the influence of the epidemic constitution. It is also very useful in ordinary dyspeptic suffering and cardialgia; and the combination with lactate of iron is an excellent one. Chlorosis has yielded to it, in which iron alone either failed or was not supported.—*Schmidt's Jahrb*, XCI., p. 29.—*Medical Circular*.

EDIBLE SEAWEEDS.

It is well known that on different parts of our coasts certain seaweeds are employed by the inhabitants as articles of diet. Some, as the laver (*porphyra laciniata*), is considered so great a delicacy by Devonshire people, that it finds its way even to the *marchands des comestibles* of Bond-street and Piccadilly. Dr. John Davy has recently, in conjunction with Dr. Apjohn,* investigated the properties of some seaweeds. The results at which these inquirers have arrived are deserving of attention, and should be generally known. Their experiments have been directed to determining the esculent properties of Carrageen moss (*chondrus crispus*), dulse or dyllisk (*rhodomenia palmata*), laver (*porphyra laciniata*), tangle (*laminaria digitata*), and bladder-wrack (*fucus vesiculosus*).

The following is a brief summary of the conclusions arrived at by Dr. Davy:—

The algæ mentioned contain no starch, sugar, or oily matter. *Chondrus crispus* contains a large gummy and gelatinous matter; as does also the rho-

domenia palmata, and the porphyra laciniata. Very little gum, and no gelatine, were discovered in the laminaria digitata; and only a trace of gelatinous matter appears to have been obtained from the bladderwrack. All contain more or less iodine, which is removed by maceration or bleaching. In one instance, Dr. Davy observes, the seaweed was deprived (by washing) not only of adhering saline matter, but also of a portion of its own substance, and of the iodine entering into the composition of the algæ, thereby necessarily deteriorating its value. This remark is specially applicable to *chondrus crispus*, which is largely exported from Ireland in a bleached state. Even the nitrogenous constituents appear to be diminished by the bleaching process. The point of chief interest, however, is the demonstration afforded by Dr. Apjohn, of the large amount of nitrogen contained in some seaweeds, which justifies the reputation they have amongst the poor, to whom their use, as an article of food, is chiefly restricted. The following is a tabulated account of Dr. Apjohn's experiments:—

ACCOUNT OF DR. APJOHN'S EXPERIMENTS.

	Water	Dry Matter	Per cent. of Nitrogen in Dry Matter	Protein contained in Dry Matter
<i>Chondrus crispus</i> , bleached.....	17.92	82.08	1.534	9.587
„ <i>crispus</i> , unbleached.....	21.47	78.53	2.142	13.382
<i>Gigartina mamilliosa</i>	21.55	78.45	2.198	13.737
<i>Chondrus crispus</i> , bleached	19.79	80.21	1.485	9.281
„ <i>crispus</i> , unbleached.....	19.96	80.04	2.510	15.687
<i>Laminaria digitata</i> , or Dulse Tangle	21.38	78.62	1.588	9.925
„ <i>digitata</i> , or Black Tangle	31.05	68.95	1.396	8.725
<i>Rhodomenia palmata</i> , or Dyllisk	16.56	83.44	3.485	21.626
<i>Porphyra laciniata</i> , or Laver	17.41	82.59	4.650	29.062
<i>Iridaea edulis</i>	19.61	80.39	3.068	19.300
<i>Alaria esculenta</i> , or Murlins	17.91	82.09	2.424	15.150
Means.....	20.42	79.58	2.407	15.045

The percentage of nitrogen found in various other edible substances is given by way of comparison, thus:—

	W.
Potatoes contain ... ..	.541
Flour of first quality	1.817
Beet roots (mean of 13 experiments) ...	1.848
Mangolds (mean of 3 experiments) ...	1.781
Swedish turnips (mean of 5 experiments) ...	1.843
Means	1.567

It follows from these two series that the proportion of nitrogen contained in these algæ exceeds not only that of the ordinary articles of vegetable food, but even that of wheaten flour, being as 2.407 to 1.817.

Dr. Davy suggests, further, that the iodine and bromine contained in these esculent seaweeds ren-

der them worthy of more extended use; he states that where they are commonly employed, bronchocoe is unknown, and scrofulous complaints and pulmonary consumption are rare. Apart from their culinary importance, seaweeds are in great repute as manures, wherever they are easily obtained. This is accounted for by their wealth in nitrogen, and in those inorganic substances which are essential to our cereals, especially phosphate and carbonate of lime, and one or both of the fixed alkalies. In the economy of nature, these marine plants may be regarded as exercising no less important a part than terrestrial plants. "May they not," says Dr. Davy, "be considered as purifiers of seawater, tending always to remove excess of carbonic acid, and probably of azote? and may they not be viewed as the restorers (they certainly are the collectors) of substances possessing excellent medicinal qualities, viz., iodine and bromine, which

* See the *Edinburgh New Philosophical Journal*, July, 1856.

so specially belong to them, and, in them, seem providentially saved and stored up for the use of man."

We cannot but regard this inquiry as one fraught with much interest of a scientific and a practical character. We are, therefore, much gratified to learn that two prizes of £50 and £20 respectively are now offered for the best approved essays on the application of the marine algæ and their products, as food or medicine for man and domestic animals (cattle, sheep, &c.). Competitors are required to give the results of their original investigations on seaweeds, especially on the chemistry of their nutrient principles, and must therefore prepare a series of specimens, illustrative of the best mode of collecting, preserving, and transporting, in a state fit for food, the nutritive species. It is proposed that the prizes shall be awarded by the following gentlemen:—T. C. Archer, Esq., Liverpool; Professor Balfour, Edinburgh; Dr. John Davy, Ambleside; Professor Graham, Royal Mint, London; Dr. Greville, Edinburgh; Sir W. J. Hooker, Kew; Dr. Lindsay, Perth; Sir W. C. Trevelyan, Bart., Wallington; and Professor George Wilson, Edinburgh.—*Sanitary Review*.

CLINICAL RESEARCHES ON CHLOROFORM. BY M. CHASSAIGNAC.

OF CHLOROFORM DURING PREGNANCY AND SUCKLING.—It was hard to believe that the great derangement caused in the economy by the action of chloroform would not have a deleterious action upon the state of the fœtus in the womb, or upon the state of the infant suckled by a nurse to whom chloroform had been given. Facts of this double character, of which we have been witness, although not very numerous, permit us, if not to solve the question, at least to put it in a manner to elicit, on the part of accoucheurs, information of great importance. We will say at first a few words concerning anæsthesia during pregnancy; we will occupy ourselves afterwards with anæsthesia during suckling.

The first time it happened to us to produce anæsthesia during pregnancy, was in a patient in the Hôpital St. Antoine, arrived at the fifth month of gestation, and in whom it was necessary to destroy enormous vegetations occupying the labia externa. This woman had arrived at the fifth month of pregnancy; three operations were performed at sufficiently short intervals, accompanied by the use of chloroform, and followed, notwithstanding, by severe pain. We ought to ask ourselves if the attacks of hysteria and uterine pains which happened after the two first operations, depended upon the chloroform, or upon the operation itself. As to the attacks of hysteria which followed, nearly immediately, the employment of the chloroform, it appears to us rational to attribute them to this agent. As to the uterine pains, if we carefully note that they did not come on until the third day after the operation, we shall understand that we ought to attribute them much rather to the results of the operations, and to the vulvar pains, than to the action of the chloroform. The more so as in another case, of which we have to speak, and which had not any painful after symptoms, chloroform did not in any way determine uterine contraction.

Because that, in the two cases alluded to, chloroform has not produced any dangerous effect upon pregnancy, we would be far from concluding that this agent can be always employed with impunity in that state. We think,

on the contrary, that in spite of the freedom from accidents in some cases, we ought not lightly, and without serious motives, to have recourse to anæsthesia during pregnancy.

We have to say something of chloroform during suckling. Can we cause a nurse to inhale chloroform? What influence can the anæsthesia have upon the infant?

This double question, which it would be so important to resolve by a series of careful observations, has many times presented itself to us, because our treatment of abscess of the breast not being able to be used without causing rather severe pains, we have had recourse to chloroform in a considerable number of cases, both in hospital and in private practice. In none of them have we observed any accident, and the children have not appeared to us to experience any dangerous influence from it; still, in two cases, the infants suckled by women who had inhaled chloroform, were seized with drowsiness and pallor, which lasted several hours. We have thought, then, in establishing, in a general manner, that suckling was not a contra-indication of chloroform, that it was our duty not to forget in certain cases the child suffers from the anæsthetic influence.

ON THE MEANS OF AVOIDING THE DANGERS DURING OPERATIONS PERFORMED ON THE BACK PART OF THE MOUTH.—The anæsthetic state during painful operations is for the patient such a boon, that whenever we can, without exposing them to any danger, use this precious means, it is a duty of humanity and of good surgery to do so. If, on the contrary, it is at the risk of real dangers that we spare the pain, there is an unintelligent application of anæsthetics. It is this consideration, according to us very cogent, which has caused many respectable practitioners not to use chloroform in certain operations, and particularly in those performed upon the back part of the mouth. If it were asked,—Do the operations (accompanied by hæmorrhage) performed at the back part of the mouth comport with the use of chloroform employed without special precautions? The answer ought to be, No. Can these same operations admit the employment of chloroform with the precautions that we are about to indicate? It would be improper to decide the question at present. But if after having shown the results of our experience, and the considerations which have directed our researches, we can cause those who look over these remarks to share our convictions, we shall be happy to see them deduce an affirmative conclusion. We know what grave objections have been raised by our colleagues, and even by ourselves, against anæsthesia during operations performed in the throat: Asphyxia by the passage of blood into the bronchi in a patient in whom consciousness is enchainé—let us say, rather in a great measure extinguished—by chloroform; copious hæmorrhages by involuntary deglutition of liquids during the state of half sleep and torpor which succeeds to the period of collapse. Such are the first obstacles which present themselves to the imagination. Another circumstance—the facility with which the touching of the bottom of the throat removes the anæsthesia, since, according to the remark of M. Monod, this is one of the best means of awakening consciousness in patients too strongly influenced by anæsthetics. This joined to the fact, that we are compelled by the nature of the operation itself to diminish by one-half the passage of inhalation, understanding that from the moment we open the mouth to commence the operation, the air enters it without mixture, and thus prepares the termination of the anæsthesia. All this constitutes an *ensemble* of contra-indications to the use of chloroform in these operations, and besides the horizontal position which is directed by prudence, but which has the inconvenience of rendering more difficult the execution of operations at the back of the throat, adds a new contra-indication to those which we have mentioned.

In the case of ablation of the tonsils, which we choose

for example, because the operation is frequent in young subjects, well disposed by their age for the application of the aetia, not only by reason of the fright which is inspired at the idea of all operations, but still more, and principally, by reason of the facility with which we can determine in them the desired result by chloroform. If during the anæsthetic state we could contrive to place two amygdalotomes, one upon each tonsil, to pierce at first each of them with the little fork of the instrument, which produces scarcely a few drops of blood, then in this state of things, waiting for the moment when some spontaneous manifestations indicate the awakening close at hand, we could then make their simultaneous section, with a rapidity of execution peculiar to this operation, and remove the two tonsils before the return of painful perceptions, and yet at a moment when already the patient is in a position to expel the blood which falls into the throat. We must remember that the tendency to expel from the mouth liquid bodies is, so to speak, increased by chloroform; for there are hardly any subjects who, under the influence of this agent, do not expectorate to an extent sometimes very disagreeable to those who surround them. To which we must add, that the patient lying in the horizontal, or half-oblique position, should be inclined upon the right side immediately after the section of the tonsils, in the attitude which is taken spontaneously by the sick who are so weak that they cannot sit up to vomit—a position directed for the asphyxiated by submersion, in order to facilitate in them the expulsion of liquids from the air passages.

No accident has marked the results of several operations for removal of the tonsils, proving, according to us, that by means of precautions easy to take, one can, without any danger, allow patients who have to submit to ablation of the tonsils, to participate in the advantages of anæsthesia. We shall, no doubt, discover within a short time, many other applications of this principle of "*demi-réveil*" immediately before the direct action of the cutting instrument in operations upon the throat, the tongue, and the nasal, buccal, and pharyngeal cavities. Lately we have acted in the same manner, and with full success, in a man, aged 52 years, upon whom we have performed amputation of the tongue.

[Speaking of two cases of ablation of the tonsils, performed by two French surgeons, while the patients were in a state of *complete anæsthesia*, M. Chassaing says,—]

At present, and after the deplorable accidents which have arisen in certain cases from the employment of chloroform, we should be far from counselling a like mode of operating; we will say more, it would appear to us superlatively imprudent. To employ chloroform upon a patient in the sitting posture, and an operation of this kind, under the triple imminence of syncope, asphyxia, and hæmorrhage into the interior, would be braving the dangers which, on the contrary, we have always endeavoured to avoid, by the minute precautions which have been the object of our assiduous researches. Thus we do not hesitate to proscribe, in these operations upon the throat, commencing anæsthesia, and still more, anæsthesia carried to a state of collapse; it is only at the moment when it is about to cease, and when one could certainly depend upon the return of the patient to spontaneous action, that we admit of its employment.—*Lancet*.

CONTAGIOUS TYPHUS IN CATTLE.—This important subject is, it appears, to be investigated forthwith, with a view to the adoption of precautionary measures against the introduction of the disease into this country. The Royal Agricultural Society, with the co-operation of the Government, has decided on sending a commission at once to the Continent; and we learn that Professor Simonds, of the Royal Veterinary College, has been selected for the purpose, and that he is to unite with him such assistants as he may require, and to lose no time in commencing the inquiry.

VARICOCELE CURED BY SUBCUTANEOUS LIGATURE.—Two cases are now (March 24th) in the wards of Guy's, in which Mr. Hilton applied subcutaneous ligatures of strong silk to the spermatic veins in a varicose condition, which were allowed to cut their way out. One of these is a young man who has had varicocele for three years. The operation was performed three weeks ago; the cure is perfect, the veins being felt as hard cords within the scrotum. The other case was operated upon on the 28th February, and the result is equally satisfactory. We have seen varicocele treated in a variety of ways with success; one of these was by the passage of a silver wire around the veins, as originally recommended by Vidal de Cassia. The radical cure of this affection, as our readers are aware, is often attended by considerable risk, from the inflammation which sometimes arises spreading to the cellular structures of the scrotum and cord. It is recommended, therefore, not to attempt it, unless the patient suffers great inconvenience and annoyance from the enlarged veins. In the first of the two cases the affection arose from a strain in lifting a heavy weight, and proved as serious an inconvenience as almost to incapacitate for work. We may look upon the result in these two instances as completely successful.—*Lancet*.

COMMUNICATIONS have been received from S. Cusack Esq; Mr. Lewis; J. O. B.; Dr. Cryan; Dr. Hughes; Dr. Green.

PUBLICATIONS RECEIVED.

GAIRDNER.—A Few Words on Homœopathy and Homœopathic Hospitals. By W. T. Gairdner, M.D. *Edinburgh: Black; 1857.*

MILTON.—Practical Remarks on the Treatment of Spermatorrhœa. By John L. Milton, M.R.C.S.L. Fourth Edition; *London; 1856.*

WILLIAMS.—The Ophthalmia of Ireland. By John Williams, L.R.C.S.I. *Dublin: Fennin; 1857.*

LIZARS.—Practical Observations on the Use and Abuse of Tobacco. By John Lizars, late Professor of Surgery, R.C.S.E. *Edinburgh: Lizars; 1857.*

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CIRRHOSIS OF THE LUNG.

By ROBERT MAYNE, M.B.,

Lecturer on Practice of Physic at the Carmichael School of Medicine, and Physician to the Hospitals of the South Dublin Union Workhouse.

The disease termed Cirrhosis of the Lung, has attracted no small amount of attention from pathologists, ever since the appearance of Dr. Corrigan's very original memoir (see *Dublin Journal of Medical Science*, May, 1838). Indeed, so very accurately has he described the symptoms which belong to it, and the principles of diagnosis which apply to it, that physicians now-a-days generally recognise cirrhosis of the lung in practice with considerable certainty. I shall not, therefore, dwell upon the contracted side, the displaced heart, the retracted liver, the dull percussion sound, the profuse expectoration, the occasional hæmoptysis, of cirrhosis of the lung; nor shall I enlarge upon its very equivocal stethoscopic signs, such as its mucous or muco-crepitant rales, sometimes almost exactly resembling gargouillement, its doubtful cavernous cough, its doubtful cavernous respiration, and its doubtful pectoriloquy, which cause it so closely to simulate true tubercular phthisis.

It would be equally a work of supererogation were I to describe minutely the appearances presented after death by the lung itself; for the small size of the lung, its great density, and its numerous cavities all communicating with the bronchial tubes, are familiarly known to the profession.

I need scarcely say that the extreme emaciation, the rapid pulse, the sweating, the diarrhoea, which constitute such prominent symptoms in tubercular phthisis, are either feebly marked, or altogether absent, in cirrhosis of the lung, and that this constitutes a strong mark of distinction between the two diseases.

The history of cirrhosis of the lung is, however, by no means so accurately determined, as its symptoms, its diagnosis, and its morbid appearances have been; for whilst all physicians are

pretty nearly agreed upon its symptoms, and upon the general appearance presented by the lung after death, there is the widest difference of opinion amongst writers in their explanation of its pathology.

This discrepancy of opinion is probably mainly due to the great chronicity of cirrhosis of the lung; for in this disease the patient frequently survives for many years, and thus it seldom falls to the lot of the same physician to witness both the commencement and the termination of the disease; its early history is therefore unknown or forgotten, by the time that its morbid anatomy is brought to light.

Does cirrhosis of the lung depend upon an extreme contraction of the cellular tissue of the parenchyma of the lung—a contraction which also affects the fibro-cellular envelope of the lung, and the elastic fibres of the lung; this contraction being the result of a slow inflammatory action, which causes a deposition of lymph in the tissues affected, the bronchial tubes being dilated into cells or *culs de sac*, of every variety of size; and this dilatation of the bronchial tubes being produced partly by the contractile process going on in the tissues of the lung, and partly by the expansive action of the parietes of the chest, in the acts of respiration? Or is it in reality nothing but a phase of tubercular disease of the lung, the tubercular ulcerations being arrested by the formation of pouches or cavities, which become lined by a smooth membrane, and which cease to exude tubercle? Or does it originate in cavities formed in atrophied lung, in consequence of bronchitis or tubercle, and afterwards expanded beyond their original dimensions by the inspiratory force?

Each of these theories has had its advocates. I shall relate as briefly as may be, the particulars of a case which bears strongly upon this question.

Cornelius Feeney, aged 54, was a man of uncommon strength, and of an exceedingly robust constitution. For many years he had been a farm labourer, earning his livelihood in the summer

season chiefly by mowing, notoriously one of the most laborious of field employments. By his own account he never had pain or ache until the month of July, 1855, when one night, after a very hard day's work, he was suddenly seized with rigors and other symptoms, portending an attack of fever or inflammation. Next morning he was hot and feverish; to use his own words, "he had a surfeit." His breathing soon became so short and so difficult that the surgeon of a neighbouring dispensary bled him, and pronounced his disease to be inflammation of the lung. He cannot recollect that he then suffered from pain in the side, but the sensation of "smothering" was so distressing at the time, that it still remains vividly impressed upon his memory. For several days his expectoration was scanty, he cannot remember whether it was ever bloody or rusty-coloured; but at length it suddenly became very profuse and purulent (like corruption, as he expresses it), large quantities of matter being coughed up daily. After a very doubtful convalescence, his acute symptoms gradually subsided; but he never afterwards recovered his health. The cough never left him, the expectoration never completely ceased, the breathing never regained its former freedom, and his strength was never restored. For several weeks he had been confined to bed; at length he was able to get about, and even to do a little light work; but he never regained sufficient strength to earn a day's wages.

In October, 1856 (in consequence of exposure to cold, as he believes), he was again seized with acute pulmonary symptoms; fresh fever arose, there was increased dyspnoea, increased cough, and increased expectoration. He was once more obliged to take to his bed. For two months he struggled on without medical aid; and at length, on the 6th of last December, he entered the hospital of the South Dublin Union Workhouse.

Notwithstanding his lengthened illness, he still retained considerable muscular development: he complained of incessant cough, of considerable dyspnoea, and his expectoration was very profuse, and muco-purulent.

On a careful stethoscopic examination, the left lung was found perfectly healthy; indeed the respiratory murmurs all over the left side of the chest were preternaturally clear and loud. The upper portion of the right lung was also found healthy; but its lower three-fourths appeared to be extensively diseased. *Posteriorly* from the level of the spine of the scapula downwards, and *anteriorly* and *laterally* from the level of the third rib downwards, the right side of the chest was perfectly dull on percussion. Over this dull portion of the right side of the chest, mucous râles in great variety were audible, but without any vesicular respiratory murmur whatever. In some spots the mucous râles presented a near approach to the true gurgling (gargouillement), at others they consisted of a large muco-crepitus; and so perfectly did they

drown every other sound, that neither bronchial breathing nor bronchophony could be heard.

To the eye, the ribs of the right side appeared to move much less freely in respiration than those of the left side. There was no very marked difference in girth between the two sides of the chest respectively, nor was there any very decided displacement of the heart. The ribs at the right side of the chest were not particularly crowded together, nor were the corresponding intercostal spaces particularly narrowed. Finally, to the hand, laid flat upon the ribs, the vocal resonance appeared less distinct on the right side of the chest than on the left.

Was it a case of phthisis?

This conjecture appeared improbable, because the upper part of the lung was healthy, whilst the lower portions were diseased; and still more, because the true phthisical hectic was absent. The pulse was only 80, there was little if any sweating, there was no diarrhoea, and (comparatively speaking) but little emaciation.

Was it originally a case of pneumonia, never perfectly cured, and now in a state of suppuration?

On this latter supposition I acted. The side was repeatedly blistered; he was ordered a nutrititious dietary; and iodide of potassium, amongst other remedies, was prescribed for him. On the 18th of December he had improved, and cod liver oil, with the external use of iodine, was substituted for the previous treatment. On the 24th he was still better. On the 28th he was suddenly seized with a very severe rigor, followed by profound collapse, great irritability of stomach, some diarrhoea, and extreme dyspnoea. It was evident that some terrible change was impending. On the 29th there was gangrenous fœtor of the breath and of the sputa; the latter had also assumed an olive tint. Wine was now liberally supplied to him, and he was put upon bark. On the 30th of December he died.

Post-mortem examination.—Left lung perfectly healthy. At right side of chest, pulmonary and parietal pleuræ universally adherent. At the apex of the right lung, the adhesions yielded readily to the fingers, but everywhere else they were so dense as to create considerable difficulty in the evisceration of the chest. The diaphragm adhered so closely to the base of the lung, that it was well nigh impossible to separate them. The lobes of the lung were also soldered to each other with such tenacity that the interlobal fissures were obliterated.

Here then at least were the proofs of an antecedent pleuritis, from the effects of which all parts of the serous membrane had suffered.

On making a longitudinal section of the lung, vast numbers of little cavities were displayed throughout the interior of its lower three-fourths. Some of these cavities were equal to kidney beans in size, some were as large as marbles, others scarcely exceeded the dimensions of split peas.

All of them were choke-ful of a muco-purulent secretion, exactly resembling that last expectorated; and all of them communicated freely with the bronchial tubes, which were themselves somewhat dilated. (See wood-cut).

The most remarkable feature presented by this section of the lung, was the enormous density of what remained of the pulmonary tissue. It was greyish-white in colour; it felt and looked like fibro-cartilage; very considerable force was re-

quired to tear it; and nowhere from the upper third of the lung downwards, could any trace of permeable air-cells be discovered. The three inferior fourths of the lung were in fact made up of this indurated tissue, of small cavities, and of dilated tubes. Towards the lower part of the lung, these tissues had everywhere either the olive tint or the purple hue of gangrene, and exhaled a most abominable odour. The upper fourth of the lung alone remained tolerably healthy.



There was no trace of tubercle in any part of the body.

The heart was healthy, and so were all the abdominal viscera. The head was not examined.

That this was a case of cirrhosis of the lung, cut short at a certain stage of its development by gangrene, will probably be admitted by all who inspect the annexed well-executed wood-cut, from a very accurate drawing by Mr. Connolly. That it originated in a pleuro-pneumonia, which ended in adhesions on the one hand, and in numerous little suppurating cavities communicating with the bronchial tubes, on the other, appears exceedingly probable.

Of the pleuritic element there can be no doubt, because the universal adhesions, and the thickened membrane, render this absolutely certain. Of the pneumonic element, the man's previous history, his robust health up to the very moment of his seizure, the extreme dyspnoea which accompanied the attack, the fever, the subsequent expectoration, the treatment adopted by his medical attendant, and the opinion given of his case at the

time, furnish proofs (to my mind at least) all but positively conclusive.

Had the patient survived, it may fairly be conjectured that in time a process of contraction would have ensued in the condensed pulmonary structure, and then the "contracted side," the "retracted liver," and the "displaced heart," which alone were wanting to complete the picture of confirmed cirrhosis of the lung, would have been added.

Being fully alive to the danger of arguing from the particular to the universal, in matters medical, I do not claim for this case more than its real value. To me it appears to prove, or at least to make it very probable, that a pleuro-pneumonia, which has run on to suppuration of the lung, may in process of time present all the characters of cirrhosis of the lung. There may possibly be other diseases of the lung, for aught I can tell to the contrary, which shall produce the very same effects.

In none of the examples of cirrhosis of the lung which have fallen under my own observation, however, have there been the slightest grounds for believing that the disease was the result of tu-

bercle, or "another mode in which tubercular ulcerations of the lung are occasionally arrested," to use the words of Professor Bennett, of Edinburgh.

CASE OF UN-UNITED FRACTURE SUCCESSFULLY TREATED.

By SAMUEL A. CUSACK, F. R. C. S.,
Resident Surgeon to Steeven's Hospital.

John Hughes, æt. 25, was admitted into Steeven's Hospital on the 4th of August, 1855. He is a stout healthy-looking countryman, and states, that five months ago, while attending to his business as a miller, his left side became entangled in the machinery, and that he sustained fracture of the thigh and humerus. The former was a simple fracture, and united in six weeks; the latter was compound, and remained open for 10 or 12 weeks, when it closed up after the removal of a loose splinter of bone, but continued un-united, though splints and bandages were regularly applied, up to the time of his coming into hospital. On admission it appeared that he had lost all power of using the arm; the muscles were soft and wasted, and the hand hung down from debility of the extensors of the forearm. From the appearance of the cicatrix the broken extremities appear to have protruded through the integument, a little below and to the outside of the insertion of the deltoid, and in this situation they can be felt overlapping each other, to the extent of two or three inches. The limb is rather more than an inch shorter than the other; there is a considerable degree of angular motion between the parts, and no deposition of callus, or thickening of the ends has taken place. The man walks lame; his left leg is shorter than the right, and there is much induration and thickening about the neck of the femur, where the fracture had been.

During the first three months of his being in hospital the constant application of splints and starch bandages, together with courses of mercury, iodide of potash, lime water and tonics, with generous diet, having failed in producing any amendment, on the 8th of November, an incision, an inch-and-a-half long, was made on the outer side of the arm, over the seat of fracture. Small holes were next drilled, nearly through the bone, half-an-inch on either side of, and parallel to, the line of fracture, and in these ivory pegs were placed; and the wound having been drawn together around them, the limb was secured in an angular splint. Little or no inflammation or constitutional disturbance followed the operation; and when the pegs were removed, at the end of four weeks, the wound speedily closed up, but though splints were applied for three months, union did not take place.

On the 28th of February, 1856, the operation was repeated, with the slight difference that one

hole only was drilled, perpendicular to the place of fracture, so as to pass through both bones, where, owing to the obliquity of the fracture they overlay each other. Through this a small wire was introduced, and the fibro-cartilaginous substance which connected them having been scarified, the ends of the wire were bent so as to come out through the wound. Little inflammation followed, and the limb having been secured as before, he left hospital on the 19th of March, 1856. Re-admitted April 1st, 1856. The wire was withdrawn in the beginning of May, the splints being continued some time longer with a like unsatisfactory result.

On the 31st of July a fresh incision having been made, the broken extremities were turned out of the wound and sawn off to a plane surface. After this had been done, it was found that there remained a detached piece of bone firmly adherent to the soft parts on the inner side of the fracture; this having been removed, and the parts placed in apposition, the wound was closed up. Much difficulty was experienced after this operation is counteracting the longitudinal displacement caused by the weight of the limb, now almost in a paralytic condition; and this operation also proved a failure.

On the 7th of November, 1856, profiting by the experience of the last operation, having sawn off a thin section from each bone, I connected them firmly by a copper wire, which I ran through holes bored in each bone, about half-an-inch from the fracture. The holes were drilled quite through each extremity, and the wire having been run through one hole and back through the other, was twisted together and brought out of the wound. The bones, thus firmly held together, required but little support, except to prevent angular motion, and this I effected by means of five slips of copper (such as are used as retractors), laid along the arm, and secured in position by passing four of the common india-rubber elastic bands over them. By this contrivance the wound could be washed and kept clean without any disturbance or motion. Some pain and swelling of the arm followed the operation, but subsided in a few days.

In about six weeks I found by the firmness of the limb that union had begun to take place. Soon after this callus began to be thrown out in abundance, and finding that the wire kept a small granulating wound like an issue open, I cut it as close as possible, and allowed the wound to close over it. From this period the case progressed most satisfactorily, and he began to have some use of the limb, and the muscles to regain their tone. On the 17th of March he left hospital, the wire having become embedded in callus, and the limb being perfectly solid.

In treating this case I was led to persevere in local measures from the belief that some local cause of non-union must be in operation. I was able to arrive at this conclusion from the fact that he was a young and vigorous man, free from any

present disease or constitutional taint, as well as that perfect union had taken place in the other fracture sustained at the same time. The treatment was carried out with the view—1st, of exciting a healthy amount of inflammation; 2nd, of removing, if possible, any cause of non-union; and 3rd, of placing the parts in the most favourable position.

In the two first operations ivory pegs and a wire were used for the purpose of exciting inflammation, and in the third operation the loose splinters of bone and the obliquity of the fracture were removed; in the last operation, the wire probably caused by its presence a sufficient amount of inflammation, while at the same time it acted as a mechanical agent, in holding the parts together. The causes which appear to have hindered union at the first, I think, were the loose fragments of bone, the obliquity of the fracture, and the rupture of the nutritious artery. The last of these would seem to be the chief cause, from the fact that the piece of bone removed (which was twice the size of an almond, and of that shape) contained the nutritious foramen, and was firmly adherent to the soft parts, being smooth and round, and covered with an adventitious periosteum, while the parts removed by excision were rough and angular, as if recently broken, and quite unacted upon by absorption. Probably by the time union did take place, collateral circulation had been established, sufficient to carry on the necessary process. I may mention here, in connexion with the absorption of bone, that, with the exception of slight discoloration, no change had taken place in the ivory pegs.

What the condition of the wire may be is a matter for conjecture. I have since performed the operation on a dog, but a sufficient time has not elapsed to ascertain by dissection what may be the state of the parts in that case. I should hope that it would become encysted, and cease to be a source of irritation; though there is some fear that, as the substance of the bone becomes more firmly united, absorption of the callus may take place, and the projecting wire become a cause of inconvenience. Certainly, so far, the operation has been successful, and one which I think might be used with advantage after other treatment has failed, particularly when the patient is of a good constitution, when a loose fragment of bone seems to interfere with union, and where, as in this case, the bone is very superficial, owing to the wasting of the soft parts, from long-continued disuse of the limb.

A QUANTITY of butter which was seized at the shop of a dealer in Liverpool, a few days ago, by an officer of the Health Committee of the Town Council, was found on being analyzed to be thus constituted—Butter, 47·4; chloride of sodium, 23·4; nitrate of potash, 0·8; vegetable matter, derived from Irish moss or other seaweed, with water, 28·3; total 99·9. It was an importation from America.—*Times*, April 24.

CASE OF BONY TUMOR OF THE SKULL PRODUCING PRESSURE UPON THE BRAIN.

By JOHN TOLER, M.B., F.R.C.S.I.

The perusal of Dr. Daly's interesting case of bony tumor of the sternum,* has recalled to my recollection an instance which came under my own care, of pressure upon a vital organ, by a bony tumor of a somewhat different nature, the brief particulars of which I submit to the readers of the *HOSPITAL GAZETTE*.

On the 30th of April, 1854, I was called to visit Mrs. A., a lady of dark complexion, and about 56 years of age, who, I was informed, had suddenly become speechless. I found her in bed, perfectly unable to speak, and with great difficulty able to swallow. She had a constant spasmodic twitching at the angle of the mouth, which was drawn to the right side when she smiled; the left side of the face being flaccid, and apparently fuller than natural. The tongue could only be partially protruded, but was not pushed to either side. Along with these symptoms of paralysis, she had constant somnolence and a feeble thready pulse, with extreme prostration of strength.

I was informed that Mrs. A. had been severely salivated at different times for inflammatory affections; and that in August, 1852, on awaking one morning, she presented the same sudden paralysis of speech and of deglutition as at present, with numbness and twitchings of the right arm, and tendency to stupor. On that occasion she was again put under the influence of mercury, and recovered. I also learned that during the interval she had experienced two similar attacks.

On my visit two days afterwards, this lady's daughter happened to mention, as a fact of little moment, and to which no attention had previously been paid, that her mother had a curious tumor on the left side of the head. On removing the patient's cap, I found an osseous tumor, of great hardness, occupying the upper and posterior part of the temporal, and a portion of the parietal bones. I was told that the patient first noticed this tumor about twelve years before, when it was about the size of a pea, and that it had steadily continued to increase since, its growth being accompanied all along with frequent attacks of severe head-ache.

Having no doubt that the paralytic symptoms were entirely due to pressure by this tumor, I laid aside all other treatment, and directed my attention exclusively to the attempt to arrest its tendency to growth. This I endeavoured to effect by a prolonged course of iodide of potassium, and by applying to the tumor, twice a-day, an ointment of iodine and iodide of potassium.

When I again saw this lady, on the 6th of June, there was an evident improvement in her condition. The tumor appeared to be less elevated, while her power of swallowing had returned,

* See page 81.

and she was able to speak with tolerable distinctness; she was also able to walk a considerable distance without fatigue.

There was no return of the former symptoms until last September (two years and-a-half after my first visit), when I was again called to see her, and found the utterance indistinct, but not as before quite lost; the power of swallowing, on the other hand, being even more impaired than then. Her strength was much impaired, evidently from the difficulty of taking food, she being able to swallow fluids only, and these almost drop by drop. For a time she was supported by nutritious enemata; and small blisters were applied along the sides of the neck.

After a few weeks, the power of swallowing returned, and her general health became as good as before.

I saw her on this day (March 20), she is in good health; her utterance though not perfect, is distinct and intelligible; she has complete power over her muscular movements; her strength is so far restored that she is able to walk for an hour or two each day; and she swallows perfectly well. Her intelligence, throughout, has been unaffected.

I think that I am justified in ascribing the marked improvement in the patient's existing condition, as well as the diminished frequency of the paralytic seizures, to the action of iodine upon this tumor, by the pressure of which these seizures had obviously been produced.

LECTURES ON DISEASES OF THE STOMACH.

By DR. LEES,

Physician to the Meath Hospital, Lecturer on Practice of Medicine.

VOMITING.

ITS CAUSES AND TREATMENT; FERMENTATIVE FORM WITH SARCINÆ.

Vomiting, caused by the passing of a gall stone into the duct, is also a good exemplification of the sympathetic form. It generally comes on with sudden, acute pain in the epigastrium or right hypochondrium, attended by distressing nausea, and vomiting of extremely bitter fluid; the pulse is quiet, but jaundice rapidly supervenes, and the pain often ceases suddenly; an indication, in most cases, that the calculus has passed into the intestine. In these cases, as also in those of severe vomiting, caused by the passing of a calculus from the kidney, you should give one grain of opium with one of aloe, and one of dried carbonate of soda, or from 30 to 60 drops of the solution of muriate of morphia every hour, till the pain is relieved; watching, lest narcotism be induced, though it seldom is while the pain lasts. In some cases I have given a drachm of chloroform with good effect. Dr. Prout recommended bi-carbonate of soda, in

doses of one or two drachms, dissolved in a pint of warm water, to be drank repeatedly, to allay the vomiting. I have found it useful, with the addition of two drops of dilute prussic acid to each dose. Vomiting also occurs sympathetic of ulceration of the os or cervix uteri, whether simple or malignant, in mere derangements of its natural functions, or in rupture of this viscus. It may also occur at the period of rupture of the aorta or heart. Dr. Corrigan has recorded two cases, one of a gentleman who was attacked with vomiting, which returned for three or four mornings successively, followed by the symptoms and signs of aneurism of the abdominal aorta; and another case of a "lady who was seized after breakfast with violent vomiting and colicky pains, so as to give rise to a suspicion of poisoning; but on examination the heart was found ruptured." Bertin, in his work on diseases of the heart, gives a case of rupture of the heart in which severe vomiting occurred, and he attributes the rupture to the vomiting; but it is more probable that the vomiting and spasm were themselves only symptoms of the impression made on the nervous system by the sudden lesion of such an important vital organ as the heart. In the case of the late Dr. Ball, who died of rupture of the aorta, Dr. Aquilla Smith informs me, that vomiting was one of the first symptoms. Vomiting also occurs in diseases of the peritoneum, both acute and chronic, particularly in that form termed tubercular, in which the matters vomited often present a peculiar dark-green or bluish colour (described particularly by Dr. Seymour); and on dissection we find the intestines matted together, and studded over with deposits of tubercle. In these cases the preparations of iodine internally, and the ointment of iodide of lead rubbed over the abdomen, will be found of use. 5th.—Nervous vomiting, by which I mean a form induced by some modification of innervation of the stomach, or independent affection of the gastric nerves, unconnected with any change of structure, or apparent cause of irritation, in either that viscus itself or any other part of the system. We meet with examples of it occasionally in young persons of both sexes, who, without any assignable cause, or from the effect of some sudden or violent mental impression, vomit their food repeatedly; we also meet with it in females the subjects of hysteria. It is, I think, to this form particularly that we may refer most of the cases termed by Sir Henry Marsh "regurgitating," which peculiar condition he considers to be "*essentially a neural affection*," and of which he has given a highly interesting and important account in the *Dublin Quarterly Journal* of May, 1851.

This form of vomiting often takes place without any warning, or even effort, being in some cases a species of regurgitation resembling the rumination of certain herbivorous animals; but at other times it is preceded by nausea, heartburn, and accompanied by severe retching. It may occur fasting, when a

quantity of stringy matter or bile is vomited; or it may follow the taking of any food, when the chief part is rejected; and it is curious that the most indigestible food is often retained; and though the vomiting may continue for weeks or even months, yet the loss of flesh is not always corresponding, though in some cases patients have been greatly emaciated. It is generally caused by powerful mental emotion, particularly terror, and its duration is very variable; it may be cured in a few days, or last for months, with occasional intermission, and then cease suddenly. It is very liable to relapse, but seldom if ever proves fatal. The treatment of this disease is often very difficult and uncertain; what succeeds in one case may fail in the next. A proper regulation of the mind is essential for the cure, but it is of great importance to keep the bowels open; and some obstinate cases have yielded when a slight but continuous action has been kept up by mild aperient medicine. Dr. Parry mentions a case in which every thing was rejected by the stomach, even a teaspoonful of cold water; the patient was greatly reduced, when he advised half a grain of aloë to be given every four hours, moistened only by a few drops of liquid. This was retained, and acted on the bowels, when the vomiting (which had lasted for some weeks) ceased in two days. In other cases effervescing draughts with prussic acid or laudanum will succeed; and in hysterical cases, assafoetida, valerian, creasote, will be found useful. When the patients are anæmic, the preparations of iron, quinine, calumba, and quassia may be tried. If there is pain accompanying it, give morphia, hydrocyanic acid, or belladonna. External applications are often useful, as blistering, and the blistered part dressed with muriate of morphia; or excite counter-irritation by croton oil, or tartar emetic ointment. The diet should be carefully attended to; in some cases it ought to be highly nutritive; in others a milk diet would answer best. Dr. Barlow, of Bath, cured a patient who suffered from constant vomiting by restricting her to a diet consisting wholly of fresh-made uncompressed curd, on which she subsisted for several months, and recovered perfect health. There is a peculiar kind of vomit, termed, from its appearance, "barmy or yeast vomit," to which much attention has been latterly directed, in consequence of the discovery in it (by Mr. Goodsir,*) of curious organisms, which under the microscope appear as square or slightly oblong plates, divided into four equal squares by lines which cross at right angles in the centre, and are again subdivided, so as to resemble a wool-pack, and hence he has termed them *sarcinæ ventriculi*. They vary from the 800th to the 1,000th of an inch in the length of their sides, and under a high power present



a light-brown or yellow appearance. Much discussion has arisen as to whether these bodies are of animal or vegetable nature, but Mr. Goodsir has decided that they are vegetable, belonging to the species called *alga*. The fluid vomited in these cases is exceedingly sour, slightly turbid, of a light-brown colour, but presents this peculiarity, that it begins to ferment immediately after its rejection, and becomes covered with a brown froth, like that on the top of fermenting wort, and it is in this brownish substance that these *sarcinæ* are mostly found, along with the *torula* or yeast plant. The vomiting generally occurs after meals, preceded by a burning pain in the stomach, and great flatulent distention. The presence of these microscopic plants indicate a dilated condition of the stomach, and fermentation of its contents; and though much importance has been attributed to them, as causing the symptoms and constituting the disease, yet the weight of evidence is in favour of their being merely consequences of certain morbid conditions of the stomach, accompanying a form of fermentation analogous to the *torula fermenti*. As far as we know at present, these organisms are harmless of themselves, but they are generally indicative of some obstruction at the pylorus, causing the retention of the food in the stomach, or of very serious functional disease. Dr. Turnbull, who has written a valuable work on this subject, divides the cases in which these bodies are found, into four series or groups, according to their several causes. 1st, cases in which the pylorus is obstructed by simple ulcers, or their cicatrices, or some other non-malignant disease. 2nd, cases of cancer pylori. 3rd, cases in which no disease of the stomach existed, but the pylorus was obstructed by displacement, or some other cause, as by an enlarged liver pressing on it. 4th, cases of mere functional disease; but even in these cases there is generally some cause (though of a temporary nature) which obstructs the passage of food out of the stomach. It is essentially a chronic affection, and though it may occur in young persons, yet it is most frequently met with in the middle aged. The bowels are usually constipated, and the urine (in two cases that were under my care) was highly alkaline in the morning, and presented a copious deposit of triple phosphates, with phosphate of lime; while that passed on going to bed was acid, and left no deposit. In these cases want of sleep was much complained of, and I gave the tincture of lupuline, in drachm doses, with good effect. In most of the recorded cases crystals of oxalate of lime have been detected in the urine. As to the treatment for this affection, the detection of *sarcinæ* in the matters vomited gives us the practical information, that from some cause or another the food remains too long in the stomach, and is not properly digested; we should therefore regulate both the quantity and quality of the food, so as to prevent this delay in the stomach, and the liability

* Edin. Med. and Surg. Journal, vol. lviii.

to fermentation; tender lean roast beef or mutton, strong chicken jelly, beef-tea, or mutton broth, in small quantities at a time, will generally agree; milk, and soda-water, sago, arrow-root, and rice are also of use; all fermented liquors should be avoided, and if a stimulant is requisite let them have brandy mixed with cold water. Dr. Turnbull advises the use of unfermented biscuit instead of bread. The chief remedial agents are such as tend to prevent the fermentative process; of these the bisulphite of soda (introduced into practice by Dr. Jenner) is one of the most effectual, for as it is decomposed by almost any vegetable acid, he supposed that the sulphurous acid set free, would stop fermentation, and destroy the *sarcinae*. His conjecture was right, for the fermentation was checked and the patient much benefited. It may be given in doses of ten grains to a drachm, three times a day, dissolved in water, as it is very soluble, and should be taken soon after meals, as that is the time that fermentation commences. Dr. Budd speaks highly of creasote; a minim in a pill, taken after each meal, will not only check fermentation, but often relieves the severe pain which accompanies it. He also recommends common salt, from one to two tablespoonfuls taken twice a day, in half-a-pint of water. Alkalies have been used in very large doses by patients, of their own accord; but I think they only afford temporary relief, chiefly by neutralizing the excess of acid generated in the stomach. In most cases, indeed, our treatment can be only palliative, as the causes of obstruction are generally incurable; but as I have already spoken of them in the preceding lectures, I will not recapitulate what I have said on these subjects.

THE OPERATION FOR PHYMOSIS, WITH A NEW INSTRUMENT.

By CHRISTOPHER FLEMING, M.D., M.R.I.A.,
Surgeon to the Richmond Hospital.

All practical surgeons will admit, that notwithstanding the many operations suggested for the cure of Phymosis, disappointment too often arises, from failure in the simultaneous division of the skin and lining membrane of the prepuce, when the more or less complete removal of the latter is required. Accurately as these several operations may be performed, the result is not unfrequently untoward in this respect, and its remedy is hence desirable. Moreover, the exact adjustment of the divided surfaces, without the necessity of ligature or suture, as in the operations alluded to, is equally so, quick reparation being then more speedily and more simply accomplished. These two objects have been, in not a few instances, satisfactorily attained by the assistance of a hook or tenaculum here delineated. It is represented of its required length and shape, its hooked ends varying as to size, ac-

cording to that of the orifice of the prepuce, but the points of the hooks being obliquely everted, as represented. When being used, the operator should be also provided with a curved scissors, or bistoury, in case he has an assistant; and if otherwise, with a curved spring forceps in addition. A double square of lint, cut large enough to surround the base of the glans, and shaped somewhat like a Maltese cross, with a central opening for the orifice of the urethra, should be provided; and this may be previously damped with spirits of wine and water. The operator having introduced the "Phymosis Hook" within the orifice of the urethra, and being satisfied that it has been fully introduced within it, by pressing it backwards until the resistance of the glans is felt, now compresses the extremity of the prepuce in front of the glans between the finger and thumb of the left hand, and drawing forcibly forward the hook, secures its points in the mucous lining of the prepuce, to the exclusion of the cutaneous covering. Should an assistant be present, he gently retracts the skin of the penis, whilst the operator, standing on the left side of his patient, grasps tensely with his left hand the hook, and with the right makes a partially semi-circular section, at a suitable distance, in front of the glans, with the curved scissors or bistoury, and so completes his operation. The section often turns out so satisfactorily, that the divided surfaces lie in apposition, the divided skin and mucous membrane being accurately applied to each other; indeed often the former overlapping the latter. The effect produced by the traction of the lining membrane, through the medium of the hook, and the retraction of the skin in the manner specified, must be obvious, whereby the objects in view cannot but be accomplished. The dressings are now applied in the ordinary way. I have not found any appreciable annoyance from hæmorrhage. Should the bleeding be troublesome, a slip of lint, dipped in tincture of matico, or in Ruspini's styptic, with perfectly-adjusted lateral compression, has answered all purposes for stopping it. I seldom, if ever, use ligature or suture. If such is required, it is generally towards the site of the frenum; but the necessity for such may be dispensed with by directing the sections of the prepuce so as to leave a sufficiency of skin to prevent much traction; it is, however, the portion of the wound which is slowest in being cicatrised, for reasons too obvious to particularise. In cases where a difficulty may arise in passing the hook through a very close preputial opening, a slight division at the orifice will insure its entrance. Complications may present themselves, which the surgeon must prevail



against—such as abnormal adhesion between the glans and prepuce; but such contingencies are too obvious to require any special comment.

I have only casually alluded to the local or constitutional treatment; the curative process has been accomplished, in cases treated as above noted, almost wholly by plastic adhesion; at the same time I must admit that I have been disappointed in some few, by the breaking-up of this and subsequent suppurations; and hence it is well to adopt precautions against such contingency, by lint, and by other precautions unnecessary to specify. The local treatment is very simple. The lint pledget first applied is easily removable about 24 hours after the operation, particularly if it has been kept cool and damp by iced or such applications. A narrow fold of lint can, after its removal, be substituted, and retained by a light elastic band. Even when cicatrized, all unnecessary heat and irritation should be avoided for many days, as, should the slightest crack or abrasion occur, the whole tract of the previous wound rapidly ulcerates, and becomes often very troublesome.

Proceedings of Societies.

PATHOLOGICAL SOCIETY OF DUBLIN.

At a late meeting of the Pathological Society the following interesting cases were recorded:—

Necrosis of the Lower Jaw.

On the 1st of January, 1856, Dr. Power was called upon to see a young gentleman labouring under inflammation of the cheek. The whole of the right side of the face was intensely inflamed, and of a deep-red colour, and a hard swelling extended nearly from the centre of the chin up along that side, to the temple. In the side of the cheek there were two or three small lancet openings, through which a probe could be passed to the denuded bone beneath. The constitutional symptoms were very severe; the tongue was foul; the pulse was very rapid, 120 in a minute; he laboured under the most intense pain; had had no sleep for four consecutive nights; and was extremely emaciated. It appeared that the patient had continued in this state for nearly a month previously to his being seen by Dr. Power. For more than a month afterwards, purulent matter in large quantities, and occasionally pieces of bone, made their escape from the openings in the cheek. He also laboured under profuse salivation, and the odour of his breath was abominably fetid. From all these circumstances combined, the enfeebled state of his constitution, the constant drain upon his system, and above all, from the severe pain which he endured, the patient was reduced to a truly miserable condition. His urgent symptoms were however soon relieved by proper local and constitutional treatment; and after a short time

the swelling and inflammation subsided. In the month of February he experienced a fresh attack of inflammation; and after some time an abscess formed at that part of the cheek which corresponds to the external portion of the articulation of the lower jaw. An opening was made into it, from which there issued a copious discharge of matter, which continued to flow for six months. In the month of August following, the patient presented himself at Dr. Power's house, and asked him to examine the opening of the right articulation of the jaw. On looking closely there was a small white spot visible at the aperture, which on further examination proved to be the condyle of the jaw. In about ten days after, the head, neck, and part of the coronoid process of the jaw, came away through the original opening, in a single piece. It was perfectly smooth over nearly its entire surface; there was no appearance whatever of the action of the absorbents, except where the neck had been united with the rest of the bone. The condyle presented a small spot of eburation at its superior and anterior part. It was an interesting fact that the internal maxillary artery, although it passed so close to the seat of ulceration at the neck of the bone, sustained no injury whatsoever; indeed whilst the disease lasted, the patient did not lose more than two or three drops of blood. He was seen again by Dr. Power in the month of March. A very extraordinary reparatory process had taken place; the cavity in front of the external meatus of the ear, which was caused by the condyle coming away, was completely filled up. It is a curious circumstance, and one worthy of notice, that in man when this or any other portion of the lower jaw becomes diseased and dies, the individual often gets a new piece instead of the old one. Dessault and Syme mention cases of this description. In the present instance little deformity existed; the teeth of the lower jaw projected slightly beyond and to the right side of those in the upper, and there is a kind of obliquity noticed in the movements of the jaw; the distortion however is very slight, and hardly perceptible.

Carcinoma of the Stomach.

Dr. LEES presented a specimen taken from the body of a man, æt. 52, who was admitted into the Meath Hospital on the 10th of March. At the time of his admission he presented very much the appearance of a person labouring under "Bright's disease of the kidney;" his face was pale and dropsical, his hands, feet, and legs also were swollen and œdematous, and he had ascites. He stated that he suffered from great pain in the region of the stomach, nausea, and vomiting, which came on two or three hours after swallowing his food. He complained chiefly, however, of want of sleep, from which he said that he had suffered greatly for the last four or five days.

After he came into the hospital, his abdomen

was examined by the resident pupil, who observed the existence of a large circumscribed tumor in the right hypochondrium, and which he attributed to carcinoma of the liver. On examining the abdomen the next day, it was found that the tumor had completely changed the position which it before occupied; it was now situated between the epigastrium and the umbilicus. On percussing the tumor it gave a clear tympanitic sound. He stated that he was temperate in his habits, and had always enjoyed very good health (with the exception of hæmorrhoids which bled occasionally), until five or six months after he first perceived the existence of the tumor, which was about twelve months ago. At the former period he first began to vomit, and shortly afterwards came under the care of Dr. Stokes, into the Meath Hospital. He staid there for six weeks, during the last two or three of which period, the vomiting and nausea having ceased, he thought himself perfectly cured, and left the hospital. After going out, however, his bad symptoms recurred, and then, for the first time, he perceived his feet becoming œdematous; and this œdema gradually extended over his whole body.

From these signs and symptoms we came to the conclusion that it was a case of carcinoma, affecting the anterior wall of the stomach, near its pyloric orifice. There was a remarkable circumstance connected with this tumor, which should not be omitted, viz.—the frequent change of its situation. The first day we examined the abdomen, this tumor was perfectly distinct, and in the epigastric region; yet when we came to look for it the next morning it had entirely disappeared (although of very considerable size), so that it was almost impossible to find it, and when found it was high up in the right hypochondrium. On the next day it was again visible, but never remained for two days in the same situation. His urine, which was repeatedly examined, deposited no sediment. In a few days afterwards the man died, worn out apparently by the progress of his disease.

Post-mortem examination.—When the abdominal cavity was opened, the stomach was found enormously distended, and rotated on its axis; occupying its pyloric extremity was a large tumor encircling the orifice; it was perfectly hard and resonant on percussion. The liver was next examined; it was but slightly affected, there were but three small tubera upon its surface. The spleen was perfectly healthy, as also the duodenum. The appearance presented by the lungs and heart was very remarkable: between the arch of the aorta and the trachea there was a large cancerous mass united to both, pressing upon the œsophagus; though during life the man had never complained either of dysphagia or dyspnoea. The right lung was filled with these tubera, so that upon pressing it between the fingers, they could be easily felt in its substance. The surface of the heart was covered

over by a thick layer of lymph; and just where the aorta springs from it there were several small nodules, which when examined under the microscope, were found to be of a similar nature with the large cancerous mass found in the stomach. The surface of the heart was quite reticulated. The man never presented the slightest symptoms of pericarditis, although such strong evidence of its having existed was afforded by the appearance of the heart. That this inflammation was the result of cancerous disease is highly probable, judging from the *post mortem* appearances. There are two other points in this case worthy of some attention, namely—first, the pain which the patient complained of; for it is well known that this symptom is rarely met with in cases of internal cancer; second, the œdema of the face and upper extremities, a situation in which it is rarely found as the result of cancer in the abdominal cavity.

DR. MCCLINTOCK exhibited a specimen of
Congenital Perforation of the Diaphragm,

in a male infant, born in the Lying-in Hospital. The child had come to the full time, was well developed, and its external conformation was in every respect normal. At birth the heart pulsed strongly, and the child made spontaneous efforts at respiration; but these soon became feeble, and finally ceased, in spite of every means used to sustain life. The posterior three-fourths of the left ala of the diaphragm were absent, leaving the anterior attachments, and a narrow margin of muscle, extending across this situation, in a crescentic manner. The pericardium and heart were pushed completely to the right side of the chest, and the left pleural cavity was occupied by the stomach, spleen, pancreas, left lobe of the liver, the greater part of small, and a portion of the larger intestines,—all which had passed up through the abnormal perforation. The left lung was extremely small, in fact, quite rudimentary; the right lung was of natural size, and contained air. The expansion of the left lung, in this case, was clearly impossible, owing to the free communication existing between the abdomen and left side of the thorax, whilst the right lung must have been considerably compressed by the pericardium. It is highly probable, therefore, that the cause of death was the incapacity of the pulmonary apparatus to discharge the vital function of respiration. The left lobe of the liver, it is worthy of remark, was unusually small, bearing about the same proportion to the right lobe as obtains in adult life. There was no appearance of a hernial sac enveloping the chylipoietic viscera contained in the thorax. This is a circumstance deserving attention. Cruviellier seems to think that the absence of such, even in cases of congenital diaphragmatic hernia, indicates a traumatic origin for the displacement; but such a doctrine is scarcely tenable, and receives no support from analogy.

There is one curious circumstance in the above case, however, which would seem at first to give some countenance to this notion of Cruvelhiers, viz., that the œsophagus pierced the diaphragm in the natural situation and re-entered the thorax, through the perforation, to reach the stomach. The true explanation of this circumstance will most probably be found in the original mode of development of the diaphragm.

The last meeting of this Society for the Session 1856-7, was held on Saturday, April 25th,

The President, Dr. CORRIGAN, in the Chair.

Dr. BANKS exhibited a specimen of Cerebral Apoplexy, with laceration of the Brain.

Dr. STOKES detailed the particulars of the late Dr. Ball's fatal illness, with the *post-mortem* examination.

We are obliged to hold over these two communications, with several others which were made in an earlier part of the session.

Before vacating the Chair, the PRESIDENT said, GENTLEMEN,—We have now come to the termination of the present session, and it becomes my duty to address some observations, both to my fellow-members and to the students who have attended our meetings. The first impulse on my mind on this occasion is, to return thanks to my fellow-members for the position in which they placed me. A compliment from any portion of the profession is gratifying—a compliment from any college or university to which I may belong is grateful; but when that compliment comes, not from one or two colleges or universities, but from men of various colleges and universities, with whom I have mixed for many years, both socially and professionally, I must say it is a distinction of which I feel proud, and for which I wish I could find words to express my gratitude as I feel it. The value of this society is now so fully established, that it is scarcely necessary to dwell upon the subject; but I will observe, that its value may be estimated from this fact, that men who are engaged in the turmoil of arduous avocations which weary mind and body—the senior and junior members of this society—equally devote their time at its meetings to the acquisition of knowledge—the young and the old learning in turn from one another. When such an example is presented by the members of the society to students, you, my younger friends, should truly estimate the lesson it teaches. One of the chief advantages of this society is the constant stimulus it gives to action and to improvement. Valuable suggestions and important conclusions, that might be lost or forgotten, are recorded here; and thus, through the instrumentality of this society, practical knowledge is from day to day advanced and preserved. This society possesses a feature which is peculiar to it, and to which, I believe, its success is in a great

measure due: I mean the exclusion of mere theoretical disquisitions and disputations. These, I believe, are most wisely excluded, for they are ill adapted to forward patient investigation and the discovery of truth; and an experience of twenty years in this society confirms that view. Facts as they occur are here laid before you; practical suggestions, arising from careful observation, are given to you; and thus, instead of disputations, in which there is often more room for flippant oratory than for calm thought and sound reasoning, useful facts and deductions impress themselves upon the mind, are remembered, and afterwards well weighed and considered. Another advantage of this arrangement of the society is, that no valuable time is lost; so that in each week of the session, short as is the time of meeting, a large amount of practical information is collected, and mutually communicated. But the society has other claims to put forward. The Irish School of Medicine owes to it, I think I may say, the very high status which it holds at present throughout Europe and America. To it are paid the first visits of distinguished foreigners belonging to our profession, who come amongst us; and thus it has become the means of extending the fame of the Irish School of Medicine to every part of the civilized world. I believe I am not wrong when I state, that scarcely a meeting, since the commencement of the society, has been held, that has not been attended by foreigners of eminence from one part or another of the globe. At our last two meetings we have had visitors from classic Italy and majestic Greece—Greece, which reckons amongst its highest glories its having been the birthplace of Hippocrates, the father of medicine, the philanthropist, patriot, and physician. More than two thousand years have passed since he flourished, and his writings, up to this moment, carry the impress of truth and sound observation upon them. His name will be remembered as a physician so long as there is human suffering to be relieved, and that will be so long as the human race exists. Of the anecdotes connected with his life as a patriot, who can forget his refusal, in a visitation of plague, to leave his native island for the court of an eastern king, although tempted by the offer of boundless wealth and honours, and his noble answer to the ambassador who sought to tempt him, rendered, as it has been, into verse in our own language?—

“Tell him that these, the pageants of a king,
Can never to my heart such raptures bring,
As those I feel when, as I journey on,
Some pale youth rises from the wayside stone.
With health rekindling cheek, and palms outspread,
To call down bliss on my unworthy head.”

The proceedings of this society are therefore to be esteemed not merely in a professional point of view, and as contributing to the advancement of the Irish School of Medicine, but also because they thus become a link which unites our country with every part of the world where life, and health, and

medical science are valued. Such being the success and the results of this society, now in the twentieth year of its existence, and the good it has achieved, I would not be doing justice to my own feelings, and I should be guilty of a very great omission, if I did not remind you, the younger members of the profession—for the older need it not—that to the exertions of two distinguished members of our own body—to Dr. Stokes and Professor Smith—the origination, the foundation, and much of the success of this society are due (applause). Our society opens its meetings to the medical and surgical officers of our army and navy. They are free to come here; and in a city in which there is always so large a garrison, the value of such a society cannot be overrated: for while we receive valuable contributions from them, from their experience in other climes, we, in turn, give in exchange, the information which we have been able, in our respective spheres, to acquire. During the present session fifty-five communications have been made to this society. The authors neither desire nor stand in need of any apology from me; but if the younger members need any consideration to induce them to estimate highly the value of the society, they will find it in the fact—which I am sure my fellow-members will be glad I recall—that amongst our contributors this year was one of our late presidents, whom we all so deservedly esteem and respect: I mean Sir Philip Crampton, who, notwithstanding the constant occupation of his time, came here, and with that remarkable facility of clear description which peculiarly belongs to him, gave through us to surgery his practical observations, and chose this society as the most fitting medium through which to diffuse information. I have now to address a few words to the young gentlemen who have attended our meetings during the session. You have, gentlemen, enjoyed in this society an opportunity for obtaining knowledge such as students in this city, before the establishment of the Pathological Society, never possessed. Before that time students might have learned whatever they could in the particular hospitals or schools to which they belonged; but this society being a centre to which knowledge is brought by the most distinguished of our profession from every quarter, has opened its doors to you all. No matter from what hospital, school, or college you may come, it enables you to accumulate information from all—an object that could not otherwise be accomplished. You hear the observations of men whose skill and experience are looked up to with confidence by the public and by the profession. These are opportunities, I repeat, of immense value to you—opportunities you cannot overrate, and opportunities that if now lost you can never replace. But while I would impress upon you the great value of learning pathology, that is, the study of the results of those destructive actions which terminate life, or cause loss or injury of limb, I at the same time feel it to be my duty to impress on you that

the study of pathology alone will not make you physicians or surgeons. It is to the combination of pathology with clinical research, that you must look for the acquirement of skill and knowledge that will cause you to be looked up to with confidence in your professional stations. You will see here the destruction of an organ; but you must recollect that in the great majority of instances, that destruction has not come on suddenly, but step by step. If we take, as an instance, the eye, all the tissues of which are destroyed, and sight, the most precious of our senses, is lost, this fearful result, perhaps, originated from a speck of lymph upon the iris, or still farther back, merely from increased vascularity. It was then under the control of treatment. Let me take another illustration—a diseased heart, with the valves destroyed, terminating fatally, after a long duration of pain and suffering—and the instruction here has taught you this destruction was begun by the deposition of, perhaps, a few specks of lymph upon a valve. It was then curable. It is not when this work of destruction is done that your art will be of use. No, but it will be of use to save, provided you have learned to observe and discover the first symptoms of disease, to know what is to be guarded against, and what are the evil effects of neglect, or ignorance, or inattention; and it is in your clinique in your hospitals, you must learn to recognise those symptoms and signs which tell of the first insidious and treacherous departure from health. If you combine pathology with diagnosis, you lay the foundation for being good physicians and surgeons, but not otherwise. There is, perhaps, no spectacle more pitiable than that of an ill-educated physician or surgeon standing at the bedside of a patient, in doubt and in terror, having no dependence on his knowledge, vacillating in his practise, uncertain in his conclusions. And on the other hand, there is, perhaps, no position prouder or more self-satisfying to the practitioner's own mind, than when he feels, from having educated himself well, that he holds, as it were, the scales of life and death in his hands—that he does not vacillate, and is able to distinguish, even in the interior of the body, from day to day, or week to week, those changes which tell him his art is useful, and is benefitting his patient, and that recovery is being gradually but surely brought about.

The President, (addressing Mr. JOHN CAMPBELL, who had obtained the Society's Gold Medal for the best essay on the "*Pathology and Diagnosis of the Diseases of the Rectum*,") said,—I have great pleasure, Mr. Campbell, in performing the duty which the Council have deputed to me, of bestowing upon you this medal, and in doing so I feel called upon in regard to yourself to state the circumstances under which it has been awarded, and which give it a value far beyond what at first sight it might seem to possess. It is not a reward bestowed upon the pupil of any particular school by that school, nor upon the student of a particular

college by that institution. It is given by the Pathological Society of Dublin, which invited all the students of the Dublin School of Medicine to compete for the prize. There is no exclusion. And who are the judges who award the prize? Not particular teachers. Not those who can have any interest in, or even knowledge of, the writers, but gentlemen of the highest acquirements in the profession, belonging to various schools, colleges, and universities, and who, up to the moment when I opened the envelope containing your name, were totally ignorant of the individual in whose favor they decided. These facts give the gold medal of the Pathological Society a value and importance beyond that of any other prize in the profession. Testimonials as to a man's ability and competency may be obtained often too readily, and are sometimes given from the natural affection which arises between teachers and pupils, and sometimes to mere solicitation. Here, however, none of these considerations or feelings operated, and all will coincide I think with me when I say, that to the pupil who obtains it, the gold medal of the Pathological Society must be a passport to confidence and respect wherever he goes, and that it far outweighs all personal testimonials (applause). To you, Mr. John Campbell, who have so creditably won it, and under such circumstances, I sincerely wish it may be the passport to profit and honor. In conclusion I have only to observe, on vacating the chair of President, that I return to the ranks of the society with a determination to show my thanks to my fellow members in the most effective manner I can, by directing every possible exertion to promote the success of the Pathological Society.

Bibliography.

The Prostate Gland, and its enlargement in old age. By DECMUS HODGSON, M.D. Edinburgh. London, 1856.

The author informs us in his preface that the above work is a monograph, principally founded on his inaugural dissertation at graduation, to which a gold medal was awarded by the University of Edinburgh, in the year 1855. Like essays of this kind generally, it is characterised rather by careful research into the literature of the subject of which it proposes to treat, than by much originality in the treatment of that subject. One-half of the work, which consists of 800 pages, is devoted to the consideration of the anatomy and physiology of the prostate gland, and the adjacent organs. His observations on this head, and his directions for making the dissections necessary for the examination of these important parts, are full and clear, but do not, so far as we can judge, reveal anything new respecting either the relations, structure, or functions of the prostate, or its accessory glands.

The latter portion of Dr. Hodgson's monograph, where he comes to speak of the enlargement of the prostate gland in old age, forms by much the most interesting part of the work. He speaks of prostatic hypertrophy as being met with under two forms—parenchymatous and glandular. The first he describes as an affection usually traceable to stricture or inflammation of the urethra of long standing; stone in the bladder, or some such source of irritation acting on the neck of the bladder, or prostatic urethra, and setting up chronic inflammation of the gland. The disease is not of such a nature as to enlarge the prostate to the same extent as is found in glandular hypertrophy; the prostatic urethra is not distorted or altered to any remarkable degree, although the bulk of the gland may be increased to twice its usual volume or more. By glandular hypertrophy, on the contrary, our author indicates that variety of enlarged prostate, so common in persons of advanced age, that some of the best authorities have classed it among the signs of bodily decay. This enlargement does not seem to be in any way the result of inflammation, and may go on to an amazing extent, as shown in one of the plates with which the work is furnished, in which the bladder is half filled by the enlarged gland. "From the facts adduced," Dr. Hodgson observes, "it would appear to be a property of the prostate that its glandular structure can, and does in old age, become hypertrophied to almost any extent, and somewhat altered in its general nature in consequence. The secreting surface of the prostate is by the means increased, and herein lies the safety of the gland from the danger of abscess. In the case of parenchymatous enlargement, a continuance of the chronic inflammation, which has originated the disease, after setting up the formation of puriform fluid in the glandular structure, is apt to induce the formation of general or circumscribed abscess in the substance of the gland. In glandular hypertrophy, however, abscess is very rare."

Dr. Hodgson dwells at considerable length on the use of the catheter in prostatic disease, and after going over various modes of accessory treatment, speaks in a highly practical manner of the different modes of relieving retention of urine when enlargement of the prostate makes some operative procedure for the purpose of opening the bladder unavoidable.

Our author here gives a fair statement of the merits and drawbacks of the different operations proposed in such cases, viz., puncture above the pubes, perforation of the third lobe of the prostate, and puncture through the perineum; this last method of operating in cases of retention of urine from enlarged prostate is well worthy of the attentive consideration of the practical surgeon. We are not aware that any other surgeon than Dr. Lawrie, of Glasgow, has ever had recourse to it, and notwithstanding that his case did not terminate favorably, we do not hesitate to say, that his

observations on the subject (published in the *Glasgow Medical Journal*, July, 1854, and to be found in the vol. of this Gazette for 1854, page 204) sound like good sense and good surgery.

Dr. Hodgson's Monograph is illustrated with twelve plates, explanatory of the normal and morbid anatomy of the subjects of which he writes; and, on the whole, we think our author has good reason to be satisfied with the style in which his work is brought out.

The Ophthalmia of Ireland; its nature, effects, and treatment. By JOHN WILLIAMS, A.B., T.C.D. pp. 44.

This is an exceedingly good pamphlet on ophthalmia, written evidently by one who has paid close attention to the subject. The different forms under which ophthalmia is met with are clearly described, and the practitioner will derive much assistance in the power of discriminating those, from a perusal of Mr. Williams's observations. The indications for treatment are also clearly pointed out, and show the accurate acquaintance of the author with ophthalmic pathology.

In a treatise so essentially practical, anatomical details might have been omitted; but many country practitioners may be glad to have their memory refreshed on this subject. The workhouse ophthalmia is not described as a separate form, but the very excellent paper on this subject, by Dr. Kirkpatrick, in the 42nd No. of the *Dublin Quarterly Journal*,* fully supplies this deficiency. As to the essential predisposing cause of this terrible epidemic, we do not think that Dr. Williams sufficiently recognises the agency of over crowding, so ably and satisfactorily proved by the latter author.

An Exposition of the Signs and Symptoms of Pregnancy, with some other papers on subjects connected with Midwifery. By W. F. MONTGOMERY, A.M., M.D., M.R.I.A. From the second London edition. Philadelphia, Blanchard and Lea, 1857.

In the list of new medical works we feel bound to notice the American edition of Dr. Montgomery's *Exposition of the signs and symptoms of Pregnancy*. We have already noticed this work † as one possessed of no ordinary merit; and the extreme pains taken both by the publisher and printer in bringing out the American edition, show that the author's labours have been appreciated in the New World as well as in the Old.

We are inclined to go even further than the publisher, and say, that in every point of mechanical execution, the work will be found the handsomest yet issued from the American press.

* On the Epidemic Ophthalmia in the Irish Workhouses, by Dr. Kirkpatrick. *Dublin Quarterly Journal*, May, 1856.

† See DUBLIN HOSPITAL GAZETTE, vol. iii., No. 230.

ENLARGEMENT OF THE MIDDLE LOBE OF THE PROSTATE GLAND REMOVED BY THE LATERAL OPERATION OF LITHOTOMY.

We copy from the *Lancet* the following interesting letter of Dr. Gibb:—

"Some months ago, I had under my care a case of enlargement of the middle lobe of the prostate gland, which had commenced to produce all the inconveniences and miseries arising from the obstruction to the flow of urine, from the flapping forwards of the tumor and closing the internal orifice of the urethra, like a valve, on passing urine. Now it struck me at that time, as well as on many other occasions, that in cases of this peculiar affection, where the poor patient oftentimes suffers greater misery than from the presence of a stone in the bladder, relief might be obtained permanently and effectually, by going through the steps of the lateral operation for stone, and cutting away this middle lobe. I seriously contemplated the propriety of its performance on one of my own patients, and think it as well to throw out the hint to those hospital surgeons who are in the way of giving it a trial.

"Should the result prove effectual—and I see no reason why a patient should not have as good a chance of recovery as in many cases of stone—then it will be one of the greatest triumphs of the surgical art in modern times. What surgeon will be the first to try it? I am induced to send this short note, from witnessing the operation for stone, at King's College Hospital, this day week, by Mr. Fergusson, in which that distinguished surgeon excised the middle lobe of the prostate, besides removing two calculi.

"Guildford-street, April, 1857."

The following is the case referred to:—

A stout, florid, healthy-looking man, aged 59 years, the subject of stone for some years, had been sent, ten days before, from the country, with some symptoms of disease of the bladder, especially great irritability. A stone was detected, and some enlargement of the prostate gland. It was determined to relieve him by the operation of lithotomy, as it was believed that lithotripsy would produce more suffering, from the irritable state of the bladder, and at the same time the fragments could not be easily broken, from the state of the prostate. Moreover, it was suspected that there was more than one stone.

Accordingly, on the 11th instant, the man was brought into the theatre, and given the vapour of amylene, when Mr. Fergusson proceeded to perform his usual operation. Before doing so, as was his custom, he passed a staff into the bladder, to make sure of the presence of the stone. He failed to touch it. He then passed in a short sound, and readily detected it. Having completed the operation up to the point when his left forefinger was

in the bladder, he withdrew his finger, and introduced the forceps; the gush of urine took place, but the stone did not tumble within their jaws, as we have often seen in Mr. Fergusson's operations. He did not catch the stone in his usual manner; it eluded his grasp, and he could not get it. It lay in a hollow behind the enlarged middle lobe of the prostate, which formed an obstacle to its being seized with the forceps; he, however, succeeded in removing two irregular-shaped calculi from this hollow, with sharp angles, and of a blackish colour. He then introduced a pair of small stone forceps, laid hold of the projecting lobe of the prostate, and cut it off on a level with the verumontanum, with a probe-pointed bistoury. This lobe was the size of a small walnut, and had an ulcerated fungus at its apex. The rectum was then injected with some lard and opium, and the patient was removed to his bed, very little blood, indeed, having been lost at the operation, which, from first to last, did not occupy any longer time than in any other of Mr. Fergusson's cases.

In some observations which were then made, he stated that the present was one of the most remarkable cases which had ever occurred to himself, from the obstacle which prevented his first getting the stone, which he described as an unusual enlargement of the middle lobe of the prostate. In the whole course of his experience he had not before met with such an obstruction, the stone lying behind and below it in a sort of pouch or cavity. This accounted for one of the symptoms which had annoyed this man—namely, great difficulty in getting rid of his urine. He believed the prostate caused this, but he was not prepared to find such a large tumor as was here developed. If he had rested content with merely taking out the calculi, the relief would have been only partial, and he thought of doing what had never been done before, and that was to cut-away the middle lobe. He had on several occasions, he said, taken away a portion of the prostate which had projected through the wound. But here the prostate was prominent, not lacerated, and it struck him it would be as well to remove it, which he did quite readily with a small stone forceps, and a probe-pointed bistoury. This, of course, increases the danger of the patient, but it gives him a chance of future comfort in the event of recovery. The case was most certainly an isolated one, and it is left for experience to say whether the treatment adopted was a correct proceeding.

that some of the poison had been absorbed by some scratches or cuts on his hands, which he had forgotten. He washed his hands instantly, taking ammonia and wine; but the symptoms increased; his sight grew indistinct, his memory was impaired, and a sense of fainting warned him that a poisonous dose had been absorbed. He then tried cold effusion, with temporary relief, and a powerful showerbath gave great relief for a time; but the symptoms returned at intervals of a few minutes. The jaws felt constricted, and there was a spasmodic action of the muscles of the arms, parched throat, and sense of faintness. In three hours these symptoms left, and he fell asleep. The next day he suffered from great exhaustion. This case shews the necessity of extreme caution on the part of photographers and others in the use of this highly-poisonous salt. The following will be found a safe and equally efficacious mode of removing the stains of nitrate of silver from the hands:—Moisten the stain with a saturated solution of iodide of potassium in water, and afterwards with nitric acid diluted with two parts of water; then wash in a solution of hyposulphite of soda."—*Mudras Spectator*, Feb. 2, and *Times*, April 6.

DISEASE OF THE HEART WITHOUT VALVULAR AFFECTION.—At a late meeting of the Pathological Society of London, Dr. Wilks exhibited a specimen of disease of the heart without valvular affection. This specimen came from a woman who had been under Dr. Barlow's care, in Guy's Hospital, for heart disease. She died with all the usual symptoms of cardiac derangement, as dropsy, &c. She was thirty years of age, and had not been well since an attack of acute rheumatism eighteen years before. The heart was remarkable as exemplifying the effects of a general carditis independent of disease of the valves. The serous membranes, both outside and within the heart were much thickened, indicative of a previous inflammation; and the muscular structure itself was pervaded throughout by a number of white streaks, producing what is known as the fibrous degeneration. The endocarditis had been most intense towards the apex, rather than the base, of the ventricles, and thus, probably, the absence of valvular contraction, and the existence of the other form of malady. The whole organ weighed twenty-four ounces. The left ventricle was much dilated.—*Lancet*.

TREATMENT OF NÆVUS BY THE PERCHLORIDE OF IRON.—The perchloride of iron still holds its place as a very useful agent in the treatment of some forms of nævus. Mr. Lawrence in St. Bartholomew's, and Mr. Cock and Mr. Hilton in Guy's, frequently employ it as at first proposed, by means of injection. Used in this way, its chief advantages are in cases in which the growth is too large to be ligatured or excised. Repeated injections of small quantities at a time, appears to be the most successful method, as larger ones risk sloughing. There was a case recently in the Middlesex Hospital under the care of Mr. De Morgan, in which a nævus of the middle of the upper lip spread rapidly, and ulcerated through the lip, leaving a large fissure. In this, by the use of the perchloride, much advantage has been obtained; the disease did not appear to be spreading. The child's condition is now that of a single hairlip, both edges being, however, involved in a nœvoid structure. Mr. Bowman, in two cases recently under his care, in which the nævus was on the eyelid, has employed the perchloride, introduced by a thick ligature of silk. One of these was that of an infant at the Ophthalmic, on whom we saw him operate. The nævus was about the size of a sixpence, and involved the centre of the upper eyelid, being partly cutaneous and partly under the skin. To have tied it would have involved a subsequent eversion of the lid; and it became a problem of much interest to cure it without leaving a scar. The plan adopted was to draw through its centre two large ligature threads previously soaked in the perchloride. To prevent the threads from being squeezed dry in entering the skin, punctures were made

WARNING TO PHOTOGRAPHIC ARTISTS.—Our photographic friends will do well to take warning from the following extract, taken from a Cape paper, in which it is stated that Dr. Atherstone, an eminent photographer, had nearly poisoned himself:—"It appears that in removing the stains of nitrate of silver from his hands, with that deadly poison, cyanide of potassium (the plan commonly adopted by photographers), he suddenly felt a glow through his whole frame, accompanied by a tremulous feeling. The thought flashed across his mind

in the latter with the point of a knife, and a broad needle was employed. So complete was the coagulating power of the fluid, that the threads came out quite unstained, and not a drop of blood escaped from the punctures. This having been done, a small actual cautery, about the size of a probe, was introduced into the middle of the nœvus, and made to burn subcutaneously a little patch in its centre. The seton threads were to be taken out the same evening. It was hoped that the irritation, &c., which must follow these procedures, would destroy the morbid vascularity of the part; and the plan altogether struck us as exceedingly likely to be successful, and at the same time possessing the great advantage of being quite free from risk. Its success it will be for time to determine. With the perchloride, in which the nœvus is too large to be safely tied, much patience must be exercised. Many injections will be required, and the shrinking of the vascular tissue will often not be nearly so great at the time as it will become after the lapse of a few months. As exemplifying the dangers of the ligature, we may mention that the writer assisted a fortnight ago in tying a very large nœvus on the side of the face in a case in which the infant, healthy at the time, died a week afterwards, and probably from the irritation caused.—*Medical Times and Gazette*.

THE ACTUAL CAUTERY IN CASES OF DISEASED JOINTS.—The employment of the actual cautery in certain cases of diseased joints, appears to be decidedly gaining favour in the London hospitals. It is, as many of our readers well know, a great favourite with Mr. Syme, of Edinburgh. Mr. Erichsen not unfrequently employs it, and thinks highly of its advantages; and Mr. Moore, of the Middlesex, assures us that in numerous cases under his care, and that of Mr. De Morgan, the benefits obtained from it have been most marked. The cases for which it appears best adapted are those of advancing disorganisation attended by severe pain. The gnawing pain, nocturnal startings, &c., will often cease as if by magic, after the use of the cautery, and the patient's general health, as might be expected, greatly improves. We recollect, some years ago, hearing Mr. Green remark at the bedside of a case of hip-joint disease in St. Thomas's, that the result of his experience regarding the use of setons, &c., had been, that the degree of pain measured the necessity for their employment. When severe pain existed, then they were very useful. This quite tallies with experience respecting the actual cautery. The mode of using the latter is to pencil over the surface lightly with many lines, the patient being, of course, under chloroform.—*Medical Circular*.

LONDON AND PARISIAN HOSPITALS.—From an interesting report of the Committee of Beneficent Institutions, it appears that London and Paris present a striking contrast in the methods which they adopt for affording relief to the sick poor. In London, a great part of our medical relief is dispensed at the houses of the poor themselves by the physicians and surgeons attached to our dispensaries. In Paris, on the contrary, comparatively little relief is afforded otherwise than in the hospitals themselves. Thus, in the year 1853, the number of in-patients in hospitals in Paris amounted to no less than 91,754, against only 45,808 in hospitals in London—this calculation, in the case of London, being exclusive of patients treated in workhouse infirmaries. But, on the other hand, under the system of out-door medical relief recently set on foot in Paris, 102,472 persons received gratuitous attendance, against upwards of 600,000 patients similarly relieved in London. The nearest approach to a fair comparison between London and Paris which it seems possible to make is that afforded by a statement of the sums contributed by the medical charities and the poor-rate taken together as follows.—In London, income of medical charities and poor relief, £1,150,900; in Paris, expenses of l'Administration Générale, £560,853.

COMMUNICATIONS have been received from Dr. McGee (Bellast); Dr. J. Cunack; Dr. Churchill; John Levens, Esq.; Dr. McClinton; Dr. Williams (Blackrock); E. D. James, Esq.; Dr. W. Moore; Dr. McDowell; Dr. Barton.

PUBLICATIONS RECEIVED.

HODGSON.—The Prostate Gland, and its Enlargement in Old Age. By Decimus Hodgson, M.D. London: Churchill; 1856.

HOOD.—Statistics of Insanity; a Decennial Report of Bethlem Hospital, from 1846 to 1855 inclusive. By W. Charles Hood, M.D., Resident Physician of Bethlem Hospital. London: Batten.

WINSLOW.—The Journal of Psychological Medicine and Mental Pathology. Edited by Forbes Winslow, M.D. London: Churchill; April, 1857.

NEW WORKS (OR EDITIONS)

ON MEDICINE, SURGERY, AND THE COLLATERAL SCIENCES PUBLISHED DURING THE PAST MONTH.

ACTON (W.) The functions and disorders of the Reproductive Organs in Youth, in Adult Age, and in Advanced Life, considered in their Physiological, Social, and Psychological Relations, 8vo. 7s.

ASHTON (T. J.) on the Diseases, Injuries, and Malformations of the Rectum and Anus; with Remarks on Habitual Constipation, 2d. ed. 8vo. 8s.

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CAMBRIDGE University Calendar for 1857, 12mo. 6s. 6d.

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MILLER'S (W. A.) Elements of Chemistry, Theoretical, and Practical. Part 3, Organic Chemistry, 8vo. 20s.

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SMITH (H.) on Stricture of the Urethra, 8vo. 7s. 6d.

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ON THE INUTILITY OF DEPLETION IN SYPHILITIC IRITIS.

By JOHN HAMILTON,

Surgeon to the Richmond Hospital.

I believe that in the treatment of syphilitic iritis, even the most acute cases, all that is necessary to be done is to administer mercury properly, suited to the constitution of the patient, and the nature of the case, and till full salivation; and the application of the extract of belladonna round the eye, or of the solution of atropine in the eye. I totally disagree with those authors—Mr. Tyrrell for instance—who recommend, in cases where the patient is broken down, to administer tonics, &c., till he is able to bear the mercurial course, the real fact being, that the best tonic is the mercury, combined with opium, which by expelling a depressing poison from the system, invigorates it, at the same time that it arrests the ravages of a destructive specific disease; whereas, while waiting for the effects of tonics and diet, the eye may be lost. There could not be apparently more feeble or depressed subjects than No. 3, Mary Byrne, or No. 4, John Callaghan, particularly the latter, who was literally nothing but skin and bone, with a pale sallow face, contrasting with the large red tubercles with which it was studded, and so weak he could scarcely stand; yet under the beneficial action of the mercury, while the eye was saved, his flesh, strength, and complexion, all became rapidly restored, so that in his last letter to me, he describes himself, in language more remarkable for strength than orthography, “as strong as a horse, and as fat as a wheel!”

Many surgeons do not deplete, but the large majority still do, by leeches and cupping; rarely, I believe, in this country, by venesection, as recommended by Mr. Mackenzie. During fourteen years, a very large number of cases of syphilitic iritis have been under my care in the Richmond Hospital, and I have only cupped in one case; and

with my present experience, I am sure if that case presented itself now, I should not do so. It is one of those practical questions best decided by facts. I have, therefore, taken a few cases from my case-book, which will help to prove, I trust, that depletion is unnecessary in this disease.

1. James Prendergast, *æt.* 30, a labourer, October 30, 1844, ten weeks since contracted a sore near the orifice of the urethra, where there is still a small one, presenting the characters of superficial chancre. He took no mercury. A fortnight after the chancre, the anus became tender, and six weeks after a rash broke out. Nine or ten days after the eye became inflamed.

He has iritis of the left eye, marked by very great redness, particularly intense round the cornea; slight yellowness of the iris, compared with the blue-grey of the other eye; some dulness of the aqueous humour, and irregularity of the pupil at its upper margin. Suffers pain in the eyebrow, beginning at four o'clock in the evening, and keeping him awake all night. There is a rash of scurfy papules thickly scattered over the body; very extensive condylomata round the arms; two small white raised ulcers on each tonsil. To take two grains of calomel, and one-eighth of a grain of opium, three times daily.

Nov. 4. Mouth is sore, and became so yesterday. He has taken ten pills, and had a little griping yesterday. There is great improvement in the eye, which is nearly well. The redness much lessened; the cornea and aqueous humour clear. The iris has regained its natural appearance, except that there is still slight irregularity of the upper edge of the pupil. He says he can see nearly as well as ever. For the last two nights he rubbed in some extract of belladonna round the eye, and has had no nocturnal pain. Omit the pills.

Nov. 15. The iritis is now perfectly well; the iris bright, and the same colour as the other; the pupil regular as to size, but irregular at the upper edge; but so little that it would not be noticed.

He was kept under the influence of mercury,

chiefly by frictions, for six or seven weeks, and left the hospital well; some stains of the syphilitic eruption alone remaining.

2. *Double Syphilitic Iritis cured without Depletion.*—Case taken by Mr. Frazer. Peter Cra-ven, a labourer, æt. 23, admitted February 3, 1847, into No. 1 Ward, with iritis of both eyes. There is vascularity of the conjunctiva and sclerotic in both eyes. The pupil of the right eye contracted and irregular; the left pupil larger, and the inner circle more even. The irides, naturally brown, have bright orange-coloured lymph deposited in them, chiefly round the inner ring. The tears run over his cheek, and light pains him. He has pain in the brow and temple, worst during the day. No pain in the balls of the eyes. Vision is a little dim in the left eye, and more obscure in the right. Aqueous humour clear.

On the abdomen, loins, thighs, and calves of the legs, arms, and forearms, are the drying scabs of small pustular eruption, in patches, leaving, where they have separated, small depressions. He complains of pains in the joints, and periostitis of the shoulders and sternum. The submental glands are enlarged. On the under surface of the penis, about its middle, is a cicatrix the size of a half-penny, silvery, and without hardness.

He was infected about the end of last August, (1846), and a month after admitted under Dr. MacDonnel. He remained in five weeks, when he was dismissed cured. A fortnight after the eruption appeared, preceded by headache, sick stomach, and shivering. The right eye became dim and red three weeks ago, and painful about a week since, when the left eye got bad.

Feb. 3rd. Five grains of Hyd: c. cretâ, three times a day; extract of belladonna to be smeared round the eyes.

5th. The pupil of the right eye slightly dilated; vascularity of both eyes less.

6th. His mouth is sore. Omit the pills.

8th. No pain in the eyes; vascularity diminishing; pupils dilating, but very irregular; the irides regaining their clearness and natural colour, being less yellow; vision still dim.

9th. Eyes paler; the left pupil is now dilated, and presents a curious appearance, the inner circle being quite fringed with tags of lymph, to the number of twenty, where the adhesions had existed between the iris and capsule of the lens. To take a pill night and morning.

The improvement in the eyes was accompanied by equal improvement in the eruption and pains. The mercury was continued, either in the form of Hyd: c. cretâ, or small portions of mercurial ointment, to the 11th of March. He was dismissed quite well, and the eyes in every respect natural, on the 23rd March.

3. Mary Byrne, æt. 25, rather a delicate-looking woman, who had been infected by her husband several months before, and been in the hospital with syphilitic eruption for two months,

under the care of Mr. Hamilton, with a slight attack of iritis. She left the hospital well, but returned in a fortnight, the iritis having relapsed, and become most acute, accompanied by a most alarming sloughing ulceration of the throat. She had been permitted to return home only on the condition of continuing the treatment, but had neglected entirely to do so.

Dec. 30, 1856.—The right eye presents the appearance of intense ophthalmia; the conjunctiva very red and vascular; a pink zone round the cornea; intolerance of light; profuse lachrymation, and tumid eyelids. The iris is dull, of a greenish-yellow colour, with rusty specks of lymph scattered over it. They are most numerous at the outer circle of the iris; but there is one large lump projecting at the lower and outer part of the inner circle, which is evidently the commencement of a tubercle. The pupil is contracted and irregular, rather of an oval form, and adherent at its lower margin to the lens, and also at its upper and inner edge. It is quite fixed. There is scarcely any sight. Pain in the eyeball, and in the brow and temple; becomes severe at night, but usually commences about three o'clock in the afternoon, gradually grows worse till twelve at night, when it ceases. The throat is very painful, the ulceration extending over the tonsils, and up the arches of the palate to the uvula; the surface covered with adherent ash-coloured sloughs. The adjacent parts intensely red and inflamed. A good deal of sympathetic fever; skin hot; pulse 94, full and hard; tongue white and loaded. She was put on five grains of Hyd: c. cretâ, with a quarter of a grain of opium, every fourth hour. Extract of belladonna to be smeared round the eye; and a solution of nitrate of silver, 3ii to 3i of water, to be applied freely over the throat.

Thursday, Jan. 1st. The gums were effused, and the eye at once became less inflamed, the intolerance of light and the pain less.

Sunday, 4th. Redness much diminished, pupil dilated, and the rusty deposit of lymph is evidently undergoing absorption. The throat easier, its surface clearing, and small white sloughs separating, leaving a clean red surface beneath. Mouth fully affected for the last two days.

8th. Scarcely any vascularity of the conjunctiva or sclerotics; the tubercle nearly gone; she can bear the light, and vision is returning. After this she got quite well of the throat and the iritis; the only trace of the latter being some irregularity of the pupil at the lower and outer part, where the tubercle had been. This, Mr. Hamilton thought, would be permanent. She left the hospital about the end of the month, the Hyd: c. cretâ having been continued in small doses.

4. John Callaghan, æt. 24, transmitted into No. 4 Ward of the Richmond, from the Whitworth Hospital, February 26th, 1857. He is one of the city police, and was once a stout powerful

man, but is now sickly-looking, sallow, and emaciated. A thickly scattered eruption of tubercles over the face, on the eyebrows, sides of the nose and chin. He became infected with syphilis about two months ago, and has since suffered from pains in his bones, sore throat, and eruptions, with rapid decline of health and strength. He has taken mercury irregularly. Ten days ago the right eye became tender and inflamed, and quickly got very bad. His only treatment had been one leech and a blister to the temple, and bark mixture; but he had taken no mercury for a month.

The right eye is affected with acute iritis; the sclerotic of a deep dull red, most marked round the cornea; the conjunctiva also is traversed by many large red vessels; the iris of a dull yellowish-grey, contrasting with the clear blueish-grey of the other eye; the pupil hazy and irregular, adhesion existing at the lower and outer rim, where the iris is of a dull reddish-brown, as if a tubercle was about to form there; the pupil is nearly as large as the other, perhaps slightly affected by the extract of belladonna which was applied last night; sight very much injured—though he can see me in a bright light at three feet, he cannot discern a feature of my face; intolerance of light, and some lachrymation; pain in the brow, extending to the eyeball and temple, begins at ten o'clock at night, and lasts till one o'clock, A.M. Submur. hydrarg: ʒ i, opii gr. ii. in pilulis x.

Third day. Eye somewhat clearer; the deposition of rusty-coloured lymph appears less; not so much pain last night. He has taken eight pills, but no perceptible effect on the mouth, nor any griping. The belladonna has had no influence on the pupil.

Fifth day. The mouth is sore, and there is some griping. The eye is better, and he can distinguish my features, and the studs on my shirt. To take a pill night and morning.

Seventh day. Mouth fully sore; a very decided improvement in his vision, and the appearance of the eye; the iris clearing, and the rusty lymph absorbing; pupil clear and black, and the redness much less. He bears light better; no nocturnal pain of the brow the last two nights; the eruption of tubercles on his face and body are fast disappearing.

On the twelfth day the eye was not so well, more vascular and uneasy—evidently an attempt at a relapse. By increasing the quantity of mercury for two days, he got better; all traces of the iritis afterwards entirely disappeared.

On the twenty-second day, having been quite well for several days, he requested his dismissal, wishing to go to the country. I had a letter from him a few days since, saying that he had regained strength and flesh, that the sight of the eye was as good as ever, and no traces of the eruption existed. He had continued to take the mercury so as to keep up the mercurial action in the system, altogether for about ten weeks.

5. *Syphilitic Iritis of the right eye, cured by Mercury, without Depletion.*—Case by Mr. M'Farland. William Quin, æt. 17, admitted March 12th, 1857, under Mr. Hamilton. About five months ago observed a small pimple on the prepuce, some time after connexion, which broke and healed in a week. Six or seven weeks after, an eruption (syphilitic lichen) broke out over his body, and has remained ever since; at the same time his throat became sore. He got some pills at a dispensary, which slightly affected his mouth. His eyes were tender, but the right eye became so inflamed that he was admitted on the 10th into the Whitworth, from whence he was transferred to the Richmond Hospital.

The right eye presents the usual appearances of subacute iritis; the iris dull, of a dusky-yellow colour, as compared with the clear blue-grey of the other iris; the pupil dilated (though no belladonna has been applied), a slight adhesion at the lower edge; a pink zone round the cornea, and the conjunctiva vascular; some intolerance of light and lachrymation; little pain in the brow or temple, but the sight very misty. There is an eruption thickly covering his entire body, of small papules, in many parts scurfy and shining; whitish sordened ulceration over the right tonsil, adjacent part of palate, and uvula.

March 15th. He was ordered five grains of Hydrarg: c. creta, three times a day. On the ninth day after this he became affected with griping, and the mercury had to be discontinued for a day, and then resumed twice a day for six weeks, when he was dismissed quite well. He was one of those in whom mercury does not cause ulceration of the gums or salivation; and yet its beneficial influence was not less marked. As the eye got gradually better under its use, till all trace of the iritis had disappeared, including a band of lymph, which had extended from the lower margin of the iris to the capsule of the lens, it was curious that in proportion to the improvement, the pupil became less dilated, till it reached its natural proportions. He was rather slow in getting clearness of vision; when all other symptoms had gone, some imperfection of sight continued, like a cobweb before the eye, or between him and any object he looked at.

It is understood that the Professorship of Military Surgery in Edinburgh has been conferred upon Mr. Mathews, formerly a staff-surgeon of the first class, and who, during the cholera epidemic at Madeira, held a chief appointment. Report speaks of this gentleman as a clever operator and skilful surgeon—one well fitted to fill the chair of the late Sir George Ballingall.—*Lancet*.

THE Société Médicale des Hôpitaux de Paris, which consists of the medical officers of the civil and military hospitals, has proposed a prize of 1,500 francs, to be adjudged in 1858, to the author of the best memoir on Sanguineous Congestions in Fevers. The MSS. to be addressed to M. Roger, Secrétaire, before December 31, 1857, 15 Boulevard de la Madeleine.

PASSING OF AN ASCARIS LUMBRICOIDES OUT OF THE BODY, THROUGH AN ULCER IN THE GROIN.

By ROBERT LAW, M.D.,

Physician to Sir P. Dun's Hospital, &c., &c.

At a late meeting of the Pathological Society, Professor Law exhibited an *ascaris lumbricoides*, remarkable, not for its personal appearance, for it was an indifferent specimen of this entozoon, but for the singular route by which it made its way out of the body of the individual from whom it came. It came through an ulcer in the right groin, and its history, and the circumstances connected with its exit from the body, left little doubt that the intestine was its original habitat. The subject of the case was a young man, Thomas Wright, aged 22, a printer. He had been under Dr. Law's care for more than two years, from time to time, for general delicacy, the most prominent features of which were deranged digestion and irritable bowels. In the course of the last spring he consulted him for a pain and fulness of the glands in the right groin. The pain was removed by leeches; some swelling remained, for which he was directed to apply tincture of iodine. The pain and swelling of the glands of the groin returned after some time, when he applied to Dr. Hutton, who also directed leeches, the application of which was followed by a removal of the pain. Dr. Hutton recommended him to go to the sea-side, and to bathe. He did so, but while there, an abscess formed in the right groin, which broke, and discharged a considerable quantity of purulent matter. After a few weeks he felt a pain and fulness in the right lumbar region; the fulness gradually increased, became more prominent, more tender, red on the surface, and at last burst, and gave exit to a large quantity of purulent matter. At the same time he had boils in several places of his body. He said he had no doubt that there was a communication between the abscess in the loin and in the groin, that he felt as if all the parts between the two were one stiff and painful mass. As one discharged the other discharged also. Their communication was proved by injection of fluid into the loin escaping through the opening in the groin. While things continued in this state for some time, Wright's mother came to Dr. Law in the month of August, with the worm which he now exhibited, stating that it had worked its way out of the opening in the groin; and with it came some skins of currants, that he had eaten a few days before. For some days previously he had had a craving for food, with pain through his bowels.

Dr. Law remarked that there could be no doubt that there was here an iliocæcal abscess, and that the ingesta that accompanied the entozoon proved that this animal had made its way out of the intestine and got into the abscess, and so got out of

the body. There was much interesting pathology connected with the case, which Dr. Law could not then enter into; he would content himself with noticing the migratory propensity of this particular entozoon. Andral had mentioned a case in which this entozoon had made its way into the larynx of a child, and caused suffocation. Dr. Power had, at an early meeting of the Pathological Society, produced a specimen exhibiting several entozoa of this species, occupying the ductus communis choledochus, which was much enlarged in size. They have been said to have made their way into the cavity of the peritoneum, by boring through the walls of the intestines. But this is no longer believed, because they have not the means of effecting the perforation, however disposed they might be; and besides it can hardly be conceived that such perforation would not be followed by fatal peritonitis, such as occurs when perforation takes place in typhoid fever. Dr. Law had not met with nor read of any case exactly similar to the one he now detailed. The one which most closely resembles it was one, the particulars of which were copied from the *Archiv für Pathol. Anat.* Bd. vi., into the *Half-yearly Abstract of Medical Sciences*, vol. xx., p. 74, and which is noticed in the following terms:—"Professor Luschka communicates an extraordinary case, in which through the intermediate process of a retro-peritoneal abscess, four lumbrici were found encysted in the left pleura." The following are the details of the case. A man aged 23, who two years before had had slight peritonitis, suffered in 1852 from return of this complaint, with pain in the left lumbar region; death ensued, with typhoid symptoms. In the left pleura, between the lower lobe of the lung, the thoracic wall, and the diaphragm, there was a sac formed of pseudo-membrane, in which six lumbrici, and a large quantity of brown fluid were contained. An opening in the diaphragm led into a cavity formed by adhesions between the upper end of the descending colon, the left kidney, and the diaphragm, in which also some lumbrici were contained. This cavity or abscess communicated with the descending colon by three contiguous openings, situated on a level with the under part of the spleen. In the colon also there were lumbrici.

Dr. Law noticed the points of analogy between his case and that of Professor Luschka; in both it was through the intermediate process of a *retro-peritoneal abscess*, that the entozoa reached their destination. He remarked that both cases tended to confirm the opinion that these animals do not perforate the intestine except where it is unprovided with a serous covering, and therefore when they have made their way out of the intestines, they are not within the cavity of the peritoneum. The process by which the entozoon, in Dr. Law's case, effected its escape from the body, was much more simple than that through which those in Professor Luschka's case made their way to

where they were found, there being a greater variety of structure engaged in the pathological process of the latter than of the former. Dr. Law confessed he should have found it difficult to understand how a retro-peritoneal abscess could communicate with one in the pleura, if he had not had the experience of a somewhat similar pathological fact in the blood extravasated in aneurism of the abdominal aorta, pursuing an exactly similar course into the retro-peritoneal cellular membrane, and into the cavity of the left pleura, a case of which he had recorded.

A CASE OF RAMOLLISSEMENT OF THE BRAIN, OF SEVEN YEARS' DURATION:

DEATH FROM THE FALLING OF A BUILDING—POST-MORTEM EXAMINATION.

(Read to the Belfast Clinico-Pathological Society, by the President, Dr. M'GEE.)

Preliminary history, given by a relative, a non-medical man:—

"In accordance with your wish, I send the early history of Mr. —'s illness. In May, 1844, then aged about 24 years, he experienced considerable difficulty in speaking, and had so much numbness in his right arm and hand, that he was unable to use them.

"In the first week in June he consulted my medical adviser, who said he was threatened with apoplexy. By his order the patient was bled severely, and strong purgatives were administered; but a few days after, on the receipt of some exciting intelligence, a very severe attack took place. For some weeks previous to this attack he had, at intervals, severe pain in his head, referred chiefly to the left side, with drowsiness; his face at times flushed; appetite not good; no sickness of stomach.

"On the occasion of this, his first attack, the doctor of our village saw him, again bled him, shaved the head, and applied blisters. Mr. — remained unconscious for two or three weeks, and then gradually recovered, but with loss of power of his right arm and side, and inability to speak. Blistering, especially over the crown of the head, bloodletting, and purgatives, were adopted; and after some time magnetic-galvanism was used, and the power of the leg was so far restored, that he was able to walk with a halt; but the arm remained almost useless. After some time the power of speech returned, so that he could utter single words, but could not express three or four words consecutively, even though dictated; and he often used one word in mistake for another. He could not himself read a paragraph or sentence, so as to understand it; but if he knew the subject, he would ask others to read it to him; and if read slowly, he understood it. He could neither write nor dictate a letter. In June, 1845, he expe-

rienced his first convulsive attack, and one month after had three similar attacks in one day. These were afterwards repeated, at intervals varying from one to twelve months. His state appeared little affected by those attacks; but he was on some occasions aware that they had occurred, and he was, in consequence, more than usually despondent.

"As you subsequently became his medical attendant, I need not give you further details than to state, that he was said to have been, in infancy, unusually slow in learning to speak; and in childhood and youth was more taciturn, and yet more irritable, than the generality of children. Prior to his illness he had been very closely and anxiously occupied with business matters. He was an excessive smoker.—Yours truly, A. B."

I visited him first in 1847, and I became his medical attendant early in 1848; I then found him in fair bodily health, but restless and unhappy in his mind, with the power of speech as described by his friend in the preceding history. He was able to walk with a slight limp, or rather a dragging of the right leg; the right arm of little use, being contracted, owing to the overpowering action of the flexor muscles; sense of feeling perfect; tongue slightly drawn to the right side; very little twisting of the mouth; no paralysis of either side of the face; countenance not expressive of imbecility. His memory of words was so far lost, that though he was sensible of the precise meaning of what was said to him, and aware of what he himself intended to say, he had difficulty in making himself understood, excepting by his relatives. He had no childishness nor confusion of thought, and he was clear and shrewd in matters of business. He evinced considerable fretfulness, and was wilful or wayward in his conduct. Though I was often called to visit him, in consequence of the attacks of convulsions, they had always passed away before I reached him.

The treatment adopted was chiefly expectant. Laxatives were given, and he used *cotyledon umbilicus* freely; but he did not improve, nor were the convulsive attacks rendered thereby less frequent or less severe.

Urtication and other rubefacients and stimulants were applied along the spine and nerves of the paralyzed arm, but without advantage. He derived some benefit, while under my care, from a continued use of sulphate of zinc, in five-grain doses, thrice daily; and subsequently from the use of bichloride of mercury, in doses of one-sixteenth of a grain three times a-day; both of which remedies were suggested by Sir B. Brodie, who agreed in viewing the case as one of brain-softening, and prognosed a gradual increase of the disease.

Late on the evening of 1st August, 1851, Mr. — was killed by the falling of the floor and roof of a building. He was precipitated a depth of 20 feet, and received such wounds from the stone and woodwork, that his death must have been instan-

taneous. When removed from the ruins, a few minutes after the casualty, he was quite dead. He had lost much blood from a wound in the neck. There were very severe injuries, with fractures of both superior extremities; and he had two scalp-wounds over the right side of the head.

On making a *post mortem* examination, 36 hours after death, it was found that of the two wounds of the scalp, the upper one had denuded the right parietal bone at its upper part; the lower wound was near the anterior and inferior angle of the right parietal bone, and accompanied by a fracture of three inches in length, which crossed the parietal bone diagonally, terminating superiorly in the coronal suture, and inferiorly in the right temporal bone, into which it extended about three quarters of an inch. There was very little depression of the bone. The course of the coronal suture, from the inferior angle of the right parietal bone, was marked by a narrow line of blood effused under the periosteum, one-eighth of an inch broad on the right side, gradually narrowing, till it disappeared before reaching the left temple. The bones of the cranium were pale and bloodless. When the dura mater was removed, above six ounces of serous cerebro-spinal fluid escaped, and the brain appeared much collapsed. Over both hemispheres there was slight effusion of blood under the arachnoid, following and marking the sulci of the brain's convolutions. The arachnoid was unusually firm, thickened, and somewhat opaque.

A considerable depression was observed on the left hemisphere of the brain, occupying the posterior portion of the anterior lobe, and the anterior and inferior portion of the middle lobe; taking a course from above, downward and backward. This space was filled with a soft, tremulous, and almost diffident substance, approaching in colour to black currant-jelly, mixed with whitish coagula, without fœtor, or any appearance of pus. The sac occupied a space nearly the depth of the hemisphere, the membranes forming its outer wall; the inner wall, which separated it from the ventricle, was an indurated buff-coloured substance, a quarter of an inch thick, into which the brain seemed to have been converted. This change of structure involved a small portion of the left corpus striatum. The cavity or sac contained no apoplectic clot, nor was it traversed by any membranous bands. In both hemispheres the grey substance of the brain was abnormally pale; the white substance was of the natural firmness, and very free from red points. There was no fluid in the ventricles. The plexus choroides was tinged with reddish serum, and contained near its centre a small hydatid. With the above exceptions, the cerebrum and cerebellum were, in appearance, free from disease. There was no disease observable in the arterial system. The brain, when replaced, did not nearly fill the cranium. No other part of the body was examined.

The softening found after death in this case

was not ramollissement *surrounding* a coagulum or the cyst of a coagulum, nor did the cyst, if it might be so termed, contain membranous bands or septa. Was the disease, then, *ab initio*, a case of brain-softening, or was the paralysis the result of extravasated blood; and the clot having been absorbed, was the cavity filled with the jelly-like substance? This is quite contrary to what is usually found, for "in ordinary cases of extravasation, which do not at once terminate fatally, the effused blood is soon changed in character: in a few days or weeks the thinner parts, absorbed, leave a firm dark-brown coagulum, which, after a time, assumes a firm fibrous texture, gradually changing from its dark colour to a slightly reddish tint. This mass of fibrine lessens by degrees, and at length disappears. While these changes are going on, the cavity containing the coagulum becomes lined with a distinct firm membrane, of a yellowish colour, and has frequently bands or septa of the same yellow substance. The cyst or cavity is found to be distinctly organised, often with numerous bloodvessels ramifying on it." Ramollissement has been divided into red, and white or gray—into that of the young and of the aged—of increased and of diminished arterial action. Though occurring in so young a man, I am disposed to consider the case as one of gray or white softening, or the *ramollissement* of diminished arterial action. Its cause may be found in the excessive mental fatigue which the patient experienced, even without reference to hereditary and other causes. The preliminary history given by the relative of the patient is graphically and lucidly detailed.

As is not unusual, the patient had occasional attacks of convulsions, which appeared to increase in frequency and in severity. I did not see him in any of these attacks, but I have been informed, that while the paralysis was confined to the right side, the muscles of the left side were convulsed during the attacks of eclampsia.

CLINICAL REPORTS OF SURGICAL CASES IN STEEVEN'S HOSPITAL.

By SAMUEL A. CUSACK, F.R.C.S.
Resident Surgeon to the Hospital.

Wound of the Eye by a percussion cap—Hypopium—Recovery.

James Maguire, aged 25, was admitted into hospital, as a patient of Mr. Colles, February 14, 1857. He stated that two days before admission, a splinter of a copper percussion cap had struck, and he thinks lodged in the left cornea. The eye is now red and painful; the vessels of the sclerotic and conjunctiva are much injected; there is a good deal of lachrymal discharge, and he cannot bear the light; he is feverish, and complains of great pain both in the eye and circumorbital

region. There is a small abscess at the lower margin of the cornea, which is nearly round in shape, and about one-eighth of an inch in diameter; its lower segment corresponds with the lower edge of the cornea, its upper border forms part of a lesser circle, and rises to the level of the pupil; it seems to be quite circumscribed and separate from the fluid in the anterior chamber. The copper, if present, is covered with pus, and cannot be seen. He states that he feels it as the eyelid moves over it, but it is not distinguishable by the finger or probe.

R. Pil: Col: et Opii, quartis horis.

Ext: Belladonnæ, Hirudines, iij.

During the next three days the inflammation increased, the iris became slightly discoloured and irregular, though well dilated by belladonna, and the abscess had risen rather above the lower border of the pupil.

On the 17th, the pain and inflammation having rather increased, the abscess having extended to opposite the centre of the pupil, and the cornea being rather prominent over the situation of the abscess, a small opening was made at its lower margin, by means of a cataract knife, and a large drop of pus slowly evacuated; at the same time an unsuccessful search was made with an iris forceps for the foreign body.

R. Pil: Plummeri bis in die. Omit: Pil: Cal: et Opii.

During the next week great relief was experienced from the pain and tension; the abscess rather diminished in size, and there was a slight discharge from the little opening. By the 10th of March it had diminished to about the size of a pin's head; the fragment of copper could not yet be discovered, and it seems probable that it escaped with the discharge. He left hospital on the 3rd of April. By this time there only remained a minute opaque spot in the cornea, the pupil had regained its natural size and shape, and he had nearly as good vision as in the other eye.

The case of hypopyum here detailed is interesting, as illustrating the disputed point in ophthalmic surgery, whether an abscess in the anterior chamber should be opened or not. Mr. Mackenzie is of opinion that matter should not be evacuated by the surgeon either between the layers of the cornea, or from the anterior chamber, as long as it has not extended above the level of the pupil, and when larger than this, that it may be done as a palliative measure only, and not with any hope of preventing staphyloma or disorganisation of the eye; while Mr. Guthrie and others are of a different opinion, and recommend free division of the cornea in all cases.

In the present instance, this latter plan of treatment was indicated for the removal of the foreign body, and the relief of the pain and irritation which the abscess occasioned; and also to prevent further disorganisation of the eye, and con-

sequent loss of vision; while its rounded form and immovable position seemed to indicate that it was circumscribed by lymph, and might be opened without allowing any of the aqueous humour to escape. From the result of the case it would seem that such was the fact; and had this plan of treatment not been adopted, there is every reason to suppose that staphyloma and loss of vision must have taken place.

With reference to the fragment of copper, it is difficult to say whether it had become encysted in the minute opaque spot which remained, or whether, as is more probable, it escaped with the daily discharge of matter, without having attracted the patient's attention.

Dislocation of the Shoulder reduced after ten weeks.

The following case is interesting, from the facility with which reduction was effected, under the influence of chloroform.

James Hayden, aged 18, was admitted on the 8th of April. On the 10th of February he had fallen off a rick of hay on his arm, which turned behind him. He immediately lost all power in the limb, and applied to a bone-setter, who told him that he had not sustained any serious injury. On admission he presented the usual appearance of dislocation of the humerus into the axilla. The elbow was much abducted, and the limb lengthened; the scapula moved with the arm, and the head of the bone had yielded forward a little.

Chloroform having been administered, extension was made downwards and a little backwards, with pulleys, at the same time that the head of the bone was lifted into its place, by means of a towel passed round the upper part of the limb, and drawn outwards. There was no noise or sudden movement to indicate that reduction had been effected, but on removing the pulleys, the limb had regained natural shape. The arm was secured to the side, there was no subsequent inflammation, he left hospital in a few days, and can now use the arm almost as well as ever.

BELFAST CLINICAL AND PATHOLOGICAL SOCIETY.—

The annual meeting of this Society was held on the 2nd inst., at the Belfast General Hospital; the President, Dr. M'Gee, in the chair. A large number of the medical men of this town and neighbourhood were present. A favourable and encouraging Report having been read, the President declared the results of the ballot for the new office-bearers: President, Surgeon Moore, M.D.; Vice-Presidents, Surgeon Browne, Dr. J. S. Reid, Surgeon Murney, M.D. County Vice-Presidents, Dr. Babington, Londonderry; Dr. Graves, Cookstown. Council, Surgeon Lamont, Dr. Wales, Dr. Corry, Surgeon Smith, Dr. Dill, Surgeon Mulholland. Secretaries, Dr. Drennan, Dr. Cumming, in room of the former Secretaries, who resigned. Treasurer, Dr. Halliday. Votes of thanks were then passed to the retiring Secretaries, to the Treasurer, and to Dr. M'Gee, for his conduct as President during the year.

ON FOREIGN BODIES IN THE VARIOUS MUCOUS CANALS.

BY SAMUEL HARDY, M.D.

The following cases are illustrative of the occasional effects produced by the accidental entrance of foreign substances into various mucous passages, as the mouth, nose, bladder, &c.

CASE I.

The patient himself thus narrates his own case.

July 16, 1856.—“The metal nail was in my right nostril from the age of five years, for upwards of twelve years. During that time I felt no pain nor uneasiness, except when pressed with the finger. There was a slight discharge of foetid matter, which increased whenever I had a cold. My parents consulted one of the principal surgeons of this city, who, having examined my nose, said that some part of the bone was broken, and would ultimately work out. He directed the nostril to be syringed with Hunt's solution of chloride of soda, and prescribed some pills for me.

“The discharge ceased for some years. At the age of 16 years old it returned again, when I had recourse to the chloride of soda. On using my handkerchief, about two years ago, the nail came down with slight pain.”

This nail has a deposit formed on its surface which is exactly the colour of bone, for which it was mistaken when it fell from the nose. It measures nearly three-quarters of an inch in length, and the head is about three lines broad. Its weight is 16 grains.

As the child gave no account of a nail having got into his nose, his parents first became aware of something being wrong by the occurrence of a discharge from the nostril. It must seem strange how so large a body could remain in a small cavity like the nostril, and escape the search of the surgeon who was consulted.

The examination proved that although the foreign body had been lodged in the nose for fourteen years, the organ had sustained no injury.

CASES II. AND III.

During the last summer, two cases of foreign bodies in the nose were brought to the Institution for Diseases of Children.

The first of these was a female child, aged three years. Its mother stated that on the previous day when at play, a child had stuck a piece of wood into the right nostril. She had gone to several medical institutions in order to have it extracted, but the medical attendants failed in detecting it. On placing the child before a window in a good light, a yellowish substance, very much resembling the nasal secretion, could be seen at some distance from the opening of the nostril, which was removed without any difficulty, by a small pair of

forceps. It was found to be a pointed piece of wood, about a quarter of an inch in length, broken off close to the edge of the opening, into which it was wedged.

The third case was also a female child, aged four years. On the day of its being brought to the institution, a cherry-stone had been pushed into its right nostril. Before I saw it several attempts by means of forceps had been made to extract it, which had so inflamed the nostril and irritated the child, that I directed the nose to be fomented until the day following, when the stone was removed without any difficulty.

The large size of the stone, and its being fixed firmly in the nostril, enabled me to place the child on its back, with the head raised; by this position I had the light well thrown into the nose, and the patient was better kept from moving. The instrument I used was a fine ear-forceps, with hook-like projections. The delicacy of this instrument enabled me to pass the blades over the sides of the cherry-stone, without hurting the child; while the peculiar formation of its points prevented the stone, when once grasped, from slipping away.

The cases next for consideration are those in which substances have passed from the mouth into the fauces, and from thence into the œsophagus, stomach, or lungs.

CASE IV.

In the month of October last, a little girl, aged six years, was brought to me. Her mother stated that on the morning of the day when I saw her, she had been playing with a small tin whistle, which accidentally got into her throat, where it stuck fast, until her mother pushed it down. She seemed to have been in danger of being suffocated while it remained in the œsophagus, and after the substance passed into the stomach, complained that it had scratched her very much while being pressed along. She was given a dose of castor oil. There was no evidence that any injury had been inflicted in the swallowing of the sharp-edged body.

The whistle was swallowed at nine o'clock in the morning, and was expelled on the evening of the next day, without any pain or even uneasiness.

At a meeting of the Surgical Society, held on the 16th of February, 1856,* Dr. Fleming mentioned two cases of accidents from holding foreign bodies in the mouth. In one case a penny slipped into the pharynx, and brought on a violent attack of dyspnoea. By means of a probang, the penny was passed into the stomach, but did not come away by the rectum for three weeks subsequently.

In the *American Journal of Medical Science*, a very remarkable case is mentioned by Dr. Hopkins, of a child, aged two years, who was seized with convulsions. It had frequent efforts to vomit, which were generally preceded by a loud cry, indicative of severe suffering. There was hæmi-

* *Dublin Medical Press*, 19th March.

plegia of the right side. The right leg and arm fell motionless. Different means were resorted to for the relief of those symptoms, which were the more remarkable as the child, when at ease, was perfectly conscious and playful, and without any symptom of cerebral lesion. After a dose of castor oil, vomiting took place, when a large pin, an inch in length, was expelled. Immediately the hemiplegia disappeared, and the child in a few hours was perfectly well.

Within the last few days I saw a child who had swallowed accidentally a piece of brass wire bent at one end; it was an inch and a-half long, and was passed in 36 hours after being swallowed.

As illustrative of the unusual routes taken by fish-bones, I may allude to the remarkable case published by Mr. Colles, where a fish-bone passing through the œsophagus, wounded the aorta; and to the case published by Mr. Hughes, where a fish-bone, passing into the bronchus, caused death by gangrene of the lung.

The extraordinary routes taken by pins are well known. Several cases are on record where great numbers of pins have been swallowed, and which years afterwards were extracted from various parts of the body. Mr. Spencer Wells,* Mr. Jones, Mr. H. Thompson, have published such cases; and several years ago I saw a very remarkable case of the same kind in the Richmond Hospital.

I lately had an opportunity of seeing a child who had been holding a large seed in its mouth, which escaped into one of the bronchial tubes. Change of position, and a variety of methods were tried in vain, to procure its expulsion; at length, after ten days, it was coughed up. The motion of the seed could be heard interfering with the natural respiratory murmur.

The foregoing cases sufficiently show the difficulties and dangers attendant on the accidental swallowing of foreign bodies. What we have next to consider are equally important. The subjects of these are mostly persons at the age of puberty, but frequently they are met with in those more advanced in years. When young females are brought to us complaining of pain and general uneasiness situated in the vesical region, their nervous appearance is very often more thought of than what really is the truth. Their statement may be perfectly correct, yet it may be set down as a case of hysteria. The following is a well-marked instance of this kind.

A girl, æt. 20 years, complained of distress caused by the presence of a piece of clay pipe which had escaped into her bladder. She was examined by several very competent practitioners; some were of the opinion that there was a foreign body in the bladder, while others felt strongly impressed with the belief that no such thing existed, but that the patient laboured under hysteria. Fortunately those who believed her statement

sounded the bladder, and could occasionally strike a hard body. For its removal the urethra was dilated, but this having failed, attempts were made to crush the pipe by means of lithotritic instruments.

Having succeeded in striking a hard body, and believing the girl's statement to be correct, I endeavoured to take hold of the pipe by a long hollow forceps, which, if successful, would allow the body to fall into it in such a manner as to be drawn through the urethra. I failed, however, in this, but was more fortunate in a second attempt. The bladder was fully distended by tepid water, thrown into it by a syringe; the patient was then placed in a position which would cause the pipe to come towards the urethral orifice; the water was then passed by her with as much force as possible. While the water flowed she felt something in the urethra; on examining I was able to seize and draw out the piece of pipe with my finger and thumb. It measured about an inch and a half in length, and was marked in several places by the pressure of the lithotritic instrument.

At a late meeting of the Pathological Society of London, a case somewhat similar to the foregoing was brought forward.

"A young married woman had passed a hair-pin, of the usual bent form, into the urethra, and three weeks later consulted a surgeon respecting it. Mr. Faithon, of Chesham, under whose care she came, succeeded in removing it with a forceps, without any previous incisions, or dilatation of the urethra. It was much bent in removal. It came out thickly encrusted with phosphates. She recovered quickly, and no inconvenience remained."

A very interesting case occurred lately in St. Bartholomew's Hospital, and was reported in the *Medical Times and Gazette* for December 13. A man had introduced a stick of sealing-wax down his urethra, on account of some irritation felt in the canal, about four years ago, and had let it slip into the bladder. Symptoms of stone followed, and blood had often been passed.

Lithotomy was performed upon this man, when the stick of sealing wax was found doubled on itself, and thickly coated with phosphatic deposits. In remarking upon this case, which terminated fatally, the following appears.

"Looking at the circumstances that the body in the bladder consisted of a material which, at the heat of the urine, would be softish and lose all brittleness, we think most surgeons will coincide in Mr. M'Whinnies' opinion, that it would have been unwise to have seized it in a lithotrite; it was quite possible that it might have clogged the instrument so as to render its removal a matter of difficulty."

When I read this case in the *Times and Gazette*, it struck me that where a man had carried a body of this kind for four years, it would have been a matter of great importance to have endeavoured to dissolve the wax, and work it out of the bladder. I merely suggest this, as it remains to be

* *Lancet*, January 24, 1857.

known by experiment, whether such a method of treatment could be adopted. The objection against the use of a lithotrite seems perfectly true; no doubt the wax would have clogged the instrument, and perhaps required a great deal of care and trouble in withdrawing it from the bladder.

Sealing wax is soluble in spirits of wine; but in experimenting it must be known what solvent of sealing wax the delicate muco-membrane of the bladder could bear. Spirits of wine, in its full strength, would be injurious. Are there any others, less likely to do harm, and sufficiently capable of dissolving sealing-wax? If so, might they not be injected, if a similar case occurred, and the wax be thus removed, without the necessity of resorting to so serious an operation as lithotomy?

KING AND QUEEN'S COLLEGE OF PHYSICIANS.

A meeting of the Association of the College of Physicians was held on Wednesday evening, May 6th,

Dr. CHURCHILL, V.P. of the College, in the chair.

Dr. OSBORNE made some practical observations on the effects of inhalation of various volatile substances—such as ammonia, turpentine, nitre, &c.—and expressed his regret that this form of medicinal appliance should have so much fallen into disuse. He concluded with some practical remarks on the use of tobacco, which, however, he did not consider to be used in the form of inhalation, properly so called.

Dr. H. KENNEDY narrated a very interesting case of fatty degeneration of the heart, on which pericarditis supervened. The supervention of the pericardial inflammation was marked by symptoms of cerebral or nervous irritation, while the usual physical signs were not developed. Their absence Dr. Kennedy considered to be due to effusion of purulent matter, which was found, with lymph, at the base of the heart.

Dr. LEES detailed the history of a case of athenic pupura-hæmorrhagica, which resisted treatment by ergot of rye, but yielded readily to gallic acid. In connection with the disease of pupura, Dr. Lees exhibited a beautiful drawing of apoplexy of the kidney, which had occurred after typhoid fever.

At Dr. LAW's request, Dr. A. SMITH communicated the particulars of a case of pneumonia, which had occurred in Sir P. Dun's Hospital, and which had recovered after rapid salivation. The pneumonia was of that form which is accompanied with "protrusion of the intercostal spaces, and diminished vocal resonance." Dr. Smith concluded by observing that he considered mercury to be necessary for the cure of the pneumonia of the present day.

THE FILE-CUTTER'S DISEASE.

We copy from the last number of the *British Medical Journal* the following observations by Dr. J. C. HALL, on the treatment of the "File-Cutter's Disease," but they are equally applicable to almost all forms of lead poisoning:—

"I know of scarcely any subject in the whole range of medical science of greater interest, or one more deserving the most serious attention of the profession, than the examination of the chronic effects of lead on the human frame, and of which so remarkable an example is furnished in the file-cutters of Sheffield. In the treatment of this disease, our first efforts are to be directed to the expulsion of the poisonous metal from the system, and happily (since the publication of the memoir of M. Melsens, in which he has shown most clearly, by numerous experiments, that the iodide of potassium is not only a safe, certain, and radical cure for the common forms of saturnine and mercurial poisoning, but an equally sure preventive of the injurious effects so frequently produced by emanations from lead and mercury) we have the means at our command; for I have no hesitation in stating that the iodide of potassium exerts far greater influence over the effects which arise from the poison of lead, and does more to the restoration of the body to a healthy condition than any other remedy, or combination of remedies, with which we are acquainted.

"In the treatment of lead poisoning, we shall do well to keep in view the aphorism of M. Melsens, and to consider only two things, 'the disease from the presence of the poison in the system, and the cure by the expulsion of this poison out of the system'; and the principle of treatment by the iodide of potassium is to render soluble any metallic compounds which have become fixed in the living body, and to facilitate their elimination by uniting them with a substance most readily cast out of the system. Melsens assumes that in all cases of mercurial and saturnine poisoning, that the metallic substance is in actual union with the affected part or parts, and that it is retained there in the form of some insoluble compound. He considers that the iodide of potassium, after its absorption into the blood, combines with the metallic poison, and forms with it a new and soluble salt, freeing the poison from its union with the injured part; thus, as it seems, separating it from the damaged fibre, and once more setting it afloat in the circulation. M. Melsens having shown that the compounds formed by the union of mercury and its salts with certain of the tissues can be destroyed, and that the metal, on being dissolved by the iodide of potassium, can be eliminated through the kidneys, as proved by actual chemical evidence of the presence of mercury in the urine, goes on to speculate that the elimination of lead in the same way is rendered highly probable by the solubility of the saturnine salts

and compounds in the iodide of potassium; and, by the undoubted prophylactic and curative powers of the iodide of potassium in cases of impending or actual lead poisoning. It remained, however, for Dr. Parkes, in the first instance, and more recently for Dr. Sieveking, to demonstrate that in cases of saturnine paralysis the iodide of potassium does cause the elimination of lead. That it possesses this power, any of the readers of this Journal may satisfy themselves by giving it in the next cases of paralysis from lead that may be under treatment. To demonstrate its effects, the urine must be first evaporated to dryness; the residue should then be boiled with nitro-hydrochloric acid and filtered. The filtered portion, on the addition either of sulphuretted hydrogen or of sulphide of ammonium, will give a precipitate of the sulphuret of lead, if this metal be present.

"In order to obtain the full advantages of the remedy, I think it most desirable first to give a brisk purgative and a large enema. When the iodide of potassium is administered, it is important that it should be taken fasting, in order to prevent decomposition by acids, and also that it should be given *largely diluted*. I have never given it in such large doses as M. Melsens suggests. Ten grains three times a day is the largest quantity I have yet employed. From the able translation of his memoir, by Dr. W. Budd, it will be seen that M. Melsens is of opinion that there is no evidence to show that sulphuric acid is an antidote to slow lead poisoning, but that sulphate of magnesia may be properly given in cases of poisoning by a soluble salt of lead, to act on the portion yet unabsorbed.

"Although our efforts are to be directed to remove, as speedily as possible, the poison from the system, in treating the disease to which the file-cutters are so liable, certain complications will arise, requiring that means should at once be adopted for the relief of urgent sufferings; and it will often happen that in violent attacks of lead colic, opium, in some form or other, is indispensable, either alone or combined with calomel; frictions, with an opiate embrocation and injections of warm water also, are frequently useful in affording temporary relief. Obstinate constipation more generally yields to croton oil than to any other purgative. The warm bath is always of essential service.

"In cases of paralysis and 'wrist drop,' some adequate support must be afforded to the hand and arm, and electricity or galvanism may be applied to the paralysed limbs. I find, however, in actual practice, that in the different phases of the *file-cutter's disease* all other means yield in importance to full doses of the iodide of potassium, administered in the way which I have already pointed out.

"The subject of *lead service pipes*, in connection with the supply of water to the houses of all classes of the community, is one of no little interest and importance; and one on which, did my present limits permit, a few remarks might not be out of place. That the day is not far distant when lead,

as a means for the general distribution of water, will be abandoned, I feel certain. For my own part, being of opinion that it is, as a general rule, highly dangerous to bring water into contact with this metal, I hope that lead pipes will fall into general disuse; for why employ so dangerous a metal in any portion of the transit of water to our houses, when there exist in gutta-percha, porcelain, slate, zinc, and iron, substitutes which combine the advantages of durability and cheapness with perfect freedom from danger? The best means of purifying water from the contamination of lead is by filtering it through sand and animal charcoal."

DISEASED MILK, ITS CHARACTERS AND EFFECTS.

The *Medical Times and Gazette* has been publishing a series of articles under the head of "Reports on the Relations of Food and Disease." We copy at considerable length, as being of peculiar interest, that on "Diseased Milk: its Characters and Effects."

"1. It must be remembered, that among the natural constituents of milk there are, especially among its saline parts, some which, in excess, have the effect of exerting an injurious influence on those partaking of it. On the opposite side, a diminution of certain parts of the milk, such as the casein or the fat globules, may deprive the fluid of its supporting power, and may thus, in those depending on it solely for subsistence, by negation give rise to disease. In these considerations we have opened to us the same questions as spring up in relation to the influence of the flesh of over-fed animals and exhausted animals.

"2. The limits of our science prevent us from tracing out many of the agents by which diseases may be propagated through milk as the vehicle. We take small-pox virus from a pock, or syphilis virus from a chancre, and we know that in our hands there is, in either case, a veritable poison buried on the lancet point; yet what this poison may be essentially it is impossible to tell. If, therefore, it thus concentrated before us, cannot be veritably followed out, how can it be detected in milk, where it is certainly diluted, and is but problematically present? M. Donne spent a long time in endeavouring to trace the transmission of syphilis poison through milk, and failed.

"3. As, by the difficulty just named, we are cut off from pursuing with satisfaction the direct transmission of endemic and epidemic poisons through milk, so by another difficulty we are prevented from tracing out even the more general connexion—viz., that of following milk as a poison to symptoms as effects; for in this line of inquiry the difficulty lies in isolating the special from the general; or rather, perhaps, in knowing what is the special, and what is not the general influence.

A child is at the mother's breast; the mother contracts small-pox; a few days later the child takes small-pox. How did the child contract the disease? Did it imbibe it from the maternal breath, from the milk, or by accidental inoculation? It is true that, as a counterbalance to the difficulties here noted, the acquisition of certain negative facts may, and indeed have been made. In so far as it can be proved that milk from a woman or an animal suffering from any disease may be given to a child as food, without exciting the same disease,—in so far, much valuable information is supplied.

"4. It is necessary, in examining milk containing any abnormal product, to consider the local as well as the general origin of such product. Saline substances, metallic poisons, and vegetable poisons, and some animal poisons, are at once traceable back to the general system of the mother; but other foreign matter—say pus, say blood corpuscle—may be local as well as general in their origin. They may be thrown out of the system; they may be merely from the secreting gland, the result of local disease only, or of local accident.

"Having proved the existence in milk of certain abnormal products, it is again a most prominent difficulty to connect the presence of certain of these products with any set symptoms. The effects of saline matters in excess, of fatty matters in excess, of metallic poisons, of some vegetable poisons; the effects of certain deficiencies in the nitrogenous or respiratory constituents of milk; all these we may understand as affecting the animal feeding on the milk; but of the possibility of the organic animal poisons being thus transmitted, we have yet to learn everything that is affirmative, and to learn with more accuracy that which is negative.

"Content at this time with thus pointing out for future inquirers the difficulties which have to be met, we turn now to the task of putting together such scanty materials as have been gathered, regarding the normal and abnormal properties of milk.

"The standard chemical physical qualities which should be met with in a specimen of good milk, newly drawn, are as follow:—The fluid should be of alkaline reaction: this applies to the milk of all animals. The specific gravity should be about 1013: this applies to the milk of the woman and to that of the cow. The taste should be slightly sweet, and free from saline qualities. The colour should be of a yellowish white, opaque, free from blueness on the one hand, and marked yellowness on the other. Microscopically it should present the well-known fat globules, which average about $\frac{1}{1000}$ of an inch in diameter, and are soluble in ether, but insoluble in caustic potash. These globules should float freely over each other, and present no tendency to adhere. All granular bodies having a viscid appearance and a tendency to agglutinate should be absent, as well as globules having unequal borders and dotted surfaces, or

the ordinary red corpuscles of blood. The odour of milk should be slightly aromatic, free from pungency, and from any kind of fœtor or acidity.

The natural constituents of milk vary. According to Chevalier, in a deduction from the analyses of cow's milk by Berzelius, Henry and Chevallier, Boussingault and Lebel, Quevenne, Lecann, Haidlen, F. Simon, Herberger, Poggiale, Playfair, Regnault, Payen, Lehman, Vernois and A. Becquerel, the milk of the cow should yield from 12 to 14 in the 100 of solid matters, viz., 3.6 of butter, 3.9 of casein, and from 5 to 6 of sugar of milk and salts, the water constituting the remaining part. Becquerel and Vernois found in the milk of the hospitals of Paris, a proportion of water varying from 84.9 to 97.2 per 100. The weight of butter diminished sensibly with the augmentation of water. The butter varied from 6 to 1.6 per 100, and similar variations occurred in the quantities of sugar.

"The salts of milk also undergo marked variations both in quantity and in quality, and this so much under the influence of variations of food, that possibly no normal standard of milk salts can be supplied. Following Quevenne, Chevalier gives the following saline substances as parts of milk:—

"Alkaline lactates, and often free lactic acid.

"Salts, with ammonia as the base.

"Phosphate of potassa and of soda.

"Chlorides of potassium and of sodium.

"Phosphate of magnesia.

"Phosphate and carbonate of lime.

"Fluoride of calcium.

"Silicate of iron?

"Sulphur?

"Free alkali, combined with the organic materials of the milk.

"These are but the general characteristics of good milk, but when the physical qualities above-mentioned are all present, and the proportion of casein and fat are normal, the milk may be considered as possessing all the qualities which would render it efficient as a nitrogenous and respiratory food, and, as a general rule, as free from any agent which would act deleteriously. This last rule, however, must not be accepted as absolute in the present state of our knowledge.

"From the consideration of the normal constituents and qualities of milk we may turn to those which are abnormal.

"The abnormal states are of two classes:—

"1. Those arising from modifications in the quantity of one or other of the natural constituents.

"2. Those arising from the presence of some foreign substance in the secretion.

"In milk modified by either of these sets of causes certain physical or chemical differences are met with which indicate, more or less, a diseased condition.

"In the first place, according to some observers, the milk, when passed, may have an acid reaction. This is denied by others, who opine that the acid-

ity may, in such cases, take place so rapidly after the milk is withdrawn, as to lead to an incorrect inference as to the condition of the milk before being drawn. On the other hand, it is not doubted that in certain diseased conditions, in which the suckling animal is suffering from impoverishment, or from diseases of an adynamic type, the milk is super-alkaline, and is slow in developing its power of coagulation.

"The specific gravity of milk may undergo many changes; it may be below the standard under certain diseased conditions, above it in others. We have seen that in cow's milk the water may reach 97 per cent., and that the proportion of butter and sugar may fall in a proportionate degree. Such milk is simply inefficient as an article of diet. In determining the nourishing qualities of milk it is necessary, however, to remember that the specific gravity of the fluid is not, *per se*, to be accepted as a sign of impoverished milk. On this point Dr. Hassall has some very judicious remarks:—

"According to M. Lassaigne and other observers, the ordinary specific gravity of cow's milk, at 50° Fahr., is 1031. As will presently appear by our own observations, the specific gravity is liable to the greatest variation, and but seldom reaches the density given by M. Lassaigne. It must be borne in mind, however, that temperature affects somewhat the specific gravity of milk; but unless the extremes be very great, this circumstance will scarcely make any material difference in ordinary observation, and it will be hardly necessary to employ a thermometer.

"Fat being lighter than water, according as the amount of this varies in any sample of milk, so will that milk vary in specific gravity. If the quantity be very considerable, *ceteris paribus*, the milk will be so much lighter; but if very little, the density will be so much the greater. This is readily shown by taking the specific gravity of milk after the removal of the fat, as of skim-milk or serum. If the quantity of fat be very considerable, the difference of specific gravity will amount to several degrees. Thus a milk may be of a low density from excess of fat, or it may be of high specific gravity, arising partly from the deficiency of it. In most cases, however, a high specific gravity obtains in milk possessing the ordinary per-centages of cream. In some samples we have observed both a high specific gravity and excess of cream: this must have arisen from the presence of a large quantity of cheese or sugar. It thus appears that a milk may be of a high specific gravity, and yet yield but little cream; or it may be of low specific gravity, and yet afford a very large quantity of cream; also, that the extraction of the cream increases the density of the milk several degrees."

"These facts in relation to the specific gravity of milk are important, and it may be that a milk of good quality in some cases has a low specific gravity. Whenever a low specific gravity obtains, however, the nutritive power of the milk must be

considered as at least doubtful; since, as it indicates either an abundance of water, or of fat, or of both, it indicates also, as a general rule, a deficiency of sugar and of casein, substances quite as important as the fat, in their way.

"The variations which milk may undergo, in regard to taste, are, an insipidity, due to an absence of sugar or an increase of water; an absence of the oily taste, incident to a deficiency of fat globules; an acid taste, from the presence of lactic acid in excess; and a saline taste, due to the supersecretion of one or other of the salts. In some cases of low febrile states, the milk has been so offensive to the taste as to produce nausea; in other cases it has had a soapy taste, from excess of alkali. The flavour of milk varies also with the varieties of food on which the animal is fed. From carrots, onions, and turnips it receives a special flavour. The colour of milk may vary considerably from abnormal causes. When deficient in fat globules, it loses its opacity, and has a bluish, watery appearance, such as is shown in what is called skimmed milk. Variation in colour from a deep yellow to a blue may arise from another and different cause. According to M. Fuchs, these modifications are due occasionally to the presence of an infusorium—the *Vibrio cyanogenus* in the case of blue milk, the *Vibrio xanthogenus* in the case of the yellow milk. These animalcules appear to be colourless, but may, according to their species, cause the milk to be blue or yellow. They can multiply and support themselves for a long time in an infusion of marsh mallows. The use of sea-salt appears to remove the particular condition which produces these phenomena of difference in colour. The cows from which these kinds of milk have been derived have not themselves shown any peculiar symptoms of disease, nor have they been subjected to any peculiar form of diet. The milk of the cow is the only milk, as far as we know, in which this animalcule has been detected. Bailleul has investigated the colour subject as well as Fuchs, and ascribes the phenomenon to the presence of a byssus.

"Regarding this blueness of colour, Lehman states that his observations have been limited to the ordinary manner in which milk acquires this blue tint. When freshly drawn, he says, the fluid is generally perfectly white, assuming the peculiar blue colour on the formation of the cream, which exhibits pale blue specks, extending at first scarcely a line deep, and appearing in detached groups on the surface of the otherwise white fluid. These specks become darker, and gradually increase downwards and laterally, until they commingle. The curd which separates from the cream is colourless, and the bluish cream contains rod-like colourless vibriones, similar to those described by Fuchs. Lehman has only once observed a distinct formation of byssus.

"Very rarely milk is met with having a rose-red tint. When this occurs, the fluid may be sus-

pected of containing either blood-cells, or dissolved hæmatin. This may arise from purely accidental causes, such as the rupture of some of the smaller vessels in the mamma. Indeed it is doubtful whether blood in milk is ever derived from any other source.

"The milk which passes for a few days after the commencement of lactation, to which the name of "beastings" is applied, has a peculiar turbid yellow appearance, and a strongly-marked alkaline reaction. The yellow appearance, as a general rule, goes away on the third day, but sometimes continues much longer; some instances have been adduced in which it has continued in women for many months, and has produced injurious results in the child, as we shall have occasion to show in the sequel. According to Lehman, the colostrum appearance may re-occur at any period of lactation, upon the supervention of one or other of the acute inflammatory diseases."

Selections from Recent Contributions TO PHARMACY AND MATERIA MEDICA.

On the endermic employment of Ioduretted Glycerine. by Dr. Ferdinand Szukits.—Dr. Richter was the first to introduce a solution of iodine in glycerine into practice, as ioduretted glycerine. To render the iodine more soluble, he combined it with iodide of potassium; but the degree of concentration which can be obtained by this means is too great for ordinary endermic use. Dr. Szukits, therefore, adopts the proportion of one part of iodine to five of glycerine, whereby he obtains a solution capable of being applied, except on the cervical region, and on the female breast, for a long time, without producing any other annoyance than a moderate sensation of burning. This solution is applied once a day, the painted part being covered with gutta percha paper, to prevent the evaporation of the vapours of iodine.

The cases in which Dr. Szukits adopted this method with advantage were:—in old, obstinate, encysted peritoneal effusions; in one case of excessive development of fat in the abdominal integuments of an amenorrhoeic workwoman; in a case of painless swelling of the mammary gland after parturition; in three cases of encysted ovarian tumor; in a case of sub-peritoneal fibroid tumor of the uterus; and in five cases of bed-sore. The ioduretted glycerine was applied without producing any striking result, in four cases of enlargement of the thyroid gland, and in three of scrofulous glandular swellings of the neck; in a case of infarction of the uterus, an attempt was made to paint the os uteri, with a solution of a scruple, and subsequently of half a scruple to the ounce, but it was not borne.—*Dublin Quarterly Journal*, Feb. 1857.

M. E. Robiquet recommends the use of a solution of pyrophosphate of iron, in a citro-ammoniacal liquor. The advantages of the combination he states to be, that the solution keeps for months without undergoing any change, and that it yields a syrup free from the intolerable taste of ferruginous compounds; he adds that the iron in it is chemically concealed, its presence being no longer manifested by the most sensitive re-agents. The citro-ammoniacal pyrophosphate of iron has been found particularly useful in well-marked cases of anemia, chlorosis, and chronic metritis.

"To recapitulate," adds M. Robiquet, "the combination described is a polymorphous salt, in which the metallic atom is concealed from re-agents, it contains

by weight 21.11 per cent. of iron. In a therapeutic point of view the facility with which it is assimilated by the system, the absence of all styptic taste, its perfect solubility in water, the influence, finally, which it exercises on the composition of the bones, and the functions of the blood, entitle it to the first rank among ferruginous compounds."

The following formula are appended to the paper:—*Syrup of iron*; citro-ammoniacal pyrophosphate of iron, two and a half drachms; simple syrup, twenty-nine ounces; syrup of orange flowers, three ounces; make a syrup by simple solution, and colour with a sufficient quantity of tincture of cochineal, or alkanet. Each drachm of the syrup contains about six-tenths of a grain, and a table-spoonful, about three grains of the salt of iron.

Ferruginous Comfits.—Citro-ammoniacal pyrophosphate of iron, one ounce and five drachms; divide into five hundred comfits, each of which shall contain a grain and a half of the salt.

Ferruginous Wine of Bark.—Citro-ammoniacal pyrophosphate of iron, two and a half drachms; extract of pale bark, seventy-seven grains; white wine, thirty-two ounces; to be made *secundum artem*.—*Dublin Quarterly Journal*, May, 1857.

Fumigations of essence of turpentine, in itch, after the mode proposed by M. Aubé, have been extolled by Dr. A. Anselmier. The patient on going to bed, sprinkles on the sheets, and on his usual daily clothes, about thirteen drachms of essence of turpentine. When he wakes he is cured; his bed and his clothes are no longer infected. The odour of the turpentine passes off in two or three days.—*Chemist*, January, 1857.

On the preparation and administration of Iodoform.—This product, composed of three atoms of iodine, two of carbon, and one of hydrogen, is obtained in the form of beautiful shining scales, of an orange-yellow color; a peculiar penetrating smell, resembling, when it is very faint, that of saffron; and an aromatic, sweetish taste. It is best prepared in the mode directed by M. Bouchardat, in the second edition of his *Manuel de matière médicale et de thérapeutique* (vol. ii., p. 552), viz.:—take of iodine, 100 parts; bi-carbonate of potash, 100 parts; water, 750 parts; alcohol, 250 parts; mix the entire in a flask, to be placed in a water-bath, elevating the temperature of the latter, to favour the reaction. When the liquor shall have become decolorized, add a further portion of 25 parts of iodine, and re-apply heat, renewing the addition of iodine so long as the liquor shall become decolorized; when this point has been passed, and the fluid no longer changes on the application of heat, add a few drops of a solution of caustic potash, to decolorize the solution. Filter, wash the precipitate which has been produced, consisting exclusively of crystalline scales of iodoform. The liquor, on evaporation, will yield a large quantity of crystals of iodide of potassium. The phenomena attending this operation are of the same nature as those which occur in the production of chloroform. M. Bouchardat's process gives in iodoform one-sixth of the weight of the iodine employed.

The following formulæ for the administration of this agent, have been proposed.—Iodoform, one part; sugar, fifteen parts; mucilage, as much as may be necessary; divide into lozenges of fifteen grains each. Dose, from one to twelve daily.

Iodoform has been found to possess anæsthetic properties, though in a degree far inferior to chloroform and ether. The following pomade has accordingly been used as an application to ulcerated cancers.—Simple cerate, eight parts; iodoform and wine of opium, of each, one part.

The Chemical and Physiological properties of Pepsin.—M. Boudault read an interesting memoir on this subject before the *Société de Pharmacie* of Paris, of which the following is an abstract. Pepsin is a compound found in the gastric juice of animals, from which it is

obtained as a syrupy substance, by simple evaporation. It is also precipitated in a neutral state by alcohol. Metallic salts throw it down without altering its physiological properties, which re-appear when the pepsin is separated from the salts which have precipitated it. Gastric juice contains 1.26 of pepsin, and 1.75 of saline matters; the rest consists of water and lactic acid, which latter plays an important part in the phenomena of digestion. From his experiments M. Boudault concluded that pepsin is secreted in the neutral state, but that it is to its action as a ferment that the gastric juice owes its property of converting glucose into lactic acid. On the other hand, he proved that pepsin alone, that is, in the neutral state, cannot effect digestion; it is only when glucose is changed into lactic acid that digestion can take place. Hence the sequence will be, the salivary diastase transforms the amylaceous principles of the food into glucose, which is conveyed into the stomach; there this glucose meets all the elements necessary to its change into lactic acid, and especially pepsin, the principal agent in this modification, whence results the formation of gastric juice, and consequently digestion.

Lactic acid is not, however, the only acid capable of effecting digestion. Pepsin, acidulated with hydrochloric and acetic acids, also determines the formation of gastric juice; but digestion is never so complete as with pepsin, acidulated with lactic acid.

M. Boudault detailed some experiments demonstrating the equal efficacy of artificial gastric juice prepared by himself, from pepsin obtained from the rennet of the sheep, with that of the natural fluid obtained from dogs.

The employment of pepsin as a medicine was naturally suggested by its energetic action as a digestive substance. Dr. Corvisart, who was the first to use it, obtained satisfactory results, and it was the pepsin of herbivora which he employed (*Bulletin de Thérapeutique*, vol. 47, p. 320). M. Boudault administers pepsin mixed with starch, dried at a temperature of 212° F. In this form it can be mixed with a number of medicinal substances, which do not interfere with its therapeutic action. For example, with hydrochlorate of morphia, in cases of violent cardialgia; with strychnia, where it is desirable to stimulate the peristaltic motions of the stomach; with subnitrate of bismuth, lactate of iron, carbonate of iron, iodide of iron, reduced iron, &c.

Pepsin is very efficacious in dyspepsia, and in the derangements of digestion which usually attend recovery from serious or chronic diseases. Finally, it is a powerful digestive agent, in cases of consumption from insufficient nourishment.

It is given in the first spoonful of soup, or before meals, rolled up in a wafer, and either in the acid or neutral state. In the former condition it replaces the gastric juice, when the latter is not secreted in sufficient quantity in certain morbid affections; in the neutral, that is, the slightly acidulated state, it is used in cases where the stomach contains too great a quantity of acid. It is a powerful remedy.—*Bulletin Général de Thérapeutique*, 30th January, 1857.

Dr. W. Stephens Squire, gives the following as M. Boudault's process for the preparation of pepsin. The rennet bags of sheep are opened and reversed, and washed under a thin stream of water, to free them from alimentary matters, &c. The mucous membrane is then carefully scraped off with a knife, the cells are bruised in a mortar, and digested for twelve hours in distilled water. The liquid is then filtered, and neutral acetate of lead is added, which precipitates peptate of lead. This precipitate is collected and decomposed by means of sulphuretted hydrogen. Pepsin is thus liberated in solution, and is separated from the insoluble sulphide of lead by filtration. The filtered liquid represents neutral gastric juice. It is, however, necessary that it should be acid, and for this purpose lactic acid is added, until the liquid exhibits the same degree of acidity as a specimen of gastric juice obtained from the

stomach of a dog by means of a fistulous opening. If the artificial gastric juice thus obtained, be evaporated to dryness, at a temperature not exceeding 100° F., a gummy mass is obtained, which attracts moisture from the air, and is altogether a very unfit article either for sale or administration. In order to reduce it to powder, M. Boudault simply evaporates his artificial gastric juice to a syrupy consistence, and to this he adds dried starch in such proportion that one gramme shall be capable of digesting four grammes of dry fibrin, when the two are submitted together in the presence of water to the temperature of the human body.

The substance thus produced is a fawn-coloured powder, cohering somewhat together, and possessing a peculiar taste and odour. It yields to water the lactic acid and the pepsin, producing a solution of a yellowish tint, with the colour, odour, and taste of gastric juice. *Pharmaceutical Journal*, March, 1857.

ROYAL COMMISSION—MEDICAL DEPARTMENT OF THE ARMY.

The Queen has been pleased to issue a Commission under her Royal Sign Manual, to inquire into the organization, government, and direction of the Medical Department of the Army.

The reasons for the inquiry are, that it has been represented that, considering the great importance of maintaining and improving the health of all ranks of the army, at home and abroad, and of providing for their medical care and treatment in cases of disease, wounds, and other casualties whatsoever, in the most approved manner, it is expedient that certain inquiries should be made into the constitution of the medical department of the army, the mode of appointment of its officers, and the system which regulates their rank, pay, promotion, and retirement; and likewise that it is further expedient to examine into the condition and administration of the hospitals of the army, with a view to their increased efficiency.

The objects of the Commission are:—To inquire into the mode by which candidates for first commissions are selected, and the system adopted for their promotion and routine of service; also the mode adopted in regard to their pay and retiring allowances.

To inquire into the means now adopted for acquiring, keeping up, and adding to the professional knowledge of the officers of the medical department; and to consider whether it will be expedient to encourage them to combine civil practice where compatible with military duty.

To inquire into the operation of the regulations now in force, with a view to the prevention of disease in the army, both at home and abroad, as regards accommodation, encampments, clothing, rations, and other matters relating thereto, having regard to the various climates to which the troops are exposed, and the duties and responsibility of the medical authorities on these matters.

To inquire into the state and condition of military hospitals, both general and regimental.

Also into the system adopted in the same, or the treatment of the soldiers, and the powers possessed or exercised by the medical superintendents or other functionaries in such hospitals, for providing diet, medicines, and every requisite for the medical and surgical treatment of the patients under their charge, together with the character of the diet, medical comforts, furniture, and other hospital supplies.

To inquire generally as to the expenditure of such hospitals, and the financial control now exercised in and over the same, and the relative authority of the various departments whose functions are exercised within the hospitals.

To inquire into the rules and regulations, or the practice in force, for invaliding and discharging the

soldiers of the army, when brought forward for discharge as unfit for further service.

To inquire into the system of management and treatment of, and the provision made for, patients in civil hospitals, whether in immediate connection with the army or otherwise; and to consider whether such management or treatment, or any portion thereof, can be introduced with advantage in the medical department of the army.

To inquire into the expediency of making provision in the military hospitals for the officers of the army suffering from disease or accident incurred in the service, and to consider whether it would be advisable to provide in the military hospitals for the treatment and cure of lunatic officers or soldiers, or to establish a separate military hospital or hospitals for the purpose, or in any other manner to provide for the treatment of such cases.

To report what changes may be considered expedient in the organization, management, and expenditure of the medical department of the army, with a view to the utmost efficiency of this branch of the military service, and what measures may be recommended to be adopted, with a view to the preservation of the health of the troops at home and abroad; and also to report what returns or records should be kept by the medical officers of the army, with a view to the preparation of a well-digested and accurate body of military medical statistics.

The Royal Commissioners are, the Rt. Hon. Sidney Herbert; Augustus Stafford Stafford, Esq.; Colonel Sir Henry Knight Storks, K.C.B.; Andrew Smith, Esq., M.D., Director-General, Army Medical Department; Thomas Alexander, Esq., C.B.; Sir Thomas Philips; James Randal Martin, Esq., F.R.S.; Sir J. Clarke, Bart. M.D.; and J. Sutherland, Esq. M.D.

BELFAST MEDICAL SOCIETY.

The annual meeting of this old and important association was held in the library of the Society, at the General Hospital, on the 4th instant, at 7 o'clock, p.m. Dr. R. Stewart, President, in the chair.

The report of the proceedings of the Council for the past year was submitted by the secretary, Dr. Drennan, from which it appeared that the funds of the association are in a prosperous condition. The report also embodied a just tribute to the memory of two of the departed members of the society, Drs. Malcolm and M'Mullen, who had died during the year. It likewise stated, that in the course of the session, several important papers on medical topics were read at the monthly meetings, by Messrs. Heany, Browne, Murney, Dickson, and Bryce.

The usual ballot having been taken for office-bearers for the ensuing year, Surgeon Browne, B.N., was elected President; Drs. Heany and Wheeler, Vice-Presidents; and Drs. Halliday, Lamont, M'Cleery, Pirrie, Rea, and Dickson, Members of Council.

Dr. Patterson was requested to continue his services as Treasurer, and Dr. Drennan as Secretary; to each of whom a unanimous vote of thanks was given, for their past efficient services to the society.

The retiring president having been moved from the chair, and the new president having been installed therein, a most complimentary and justly deserved vote of thanks was passed by acclamation, and tendered by the president to Dr. Stewart, for the ability and zeal with which he had conducted the affairs of the association during the session then closed. Dr. Stewart acknowledged the compliment in suitable terms, and expressed the pleasure which he felt in lending his aid to promote the best interests of the body.

QUEEN'S UNIVERSITY.—George Johnston Stoney, A.M., M.R.I.A., and Professor of Natural Philosophy at Queen's College, Galway, has been elected Secretary to the Queen's University, in room of the late Robert Ball, LL.D., M.R.I.A.

BELFAST BRANCH OF THE MEDICAL BENEVOLENT FUND SOCIETY OF IRELAND.—The stated quarterly meeting of this branch of the above society, was held on the 4th instant, in the Library-room of the Belfast Medical Society, at the General Hospital—Dr. Patterson having been called to the Chair. Several applications having been duly made for relief, at the ensuing annual distribution of the Parent Society in Dublin—which is to take place next month—and each case, on a rigid inquiry, proving to be deserving of assistance, they were directed to be transmitted to Dublin accordingly, with a strong recommendation for favourable consideration. Reports were read respecting the progress made in collecting subscriptions for the current year, which were of a generally satisfactory and encouraging nature. The members of the profession, we need scarcely say, very liberally responded to the support of this invaluable society in this branch; but we are happy to find that benevolent individuals external to it, set a most laudable example, and this, too, amongst the "great and highborn," in promoting its all-important objects. It was announced that a deputation, consisting of the chairman, Dr. Gordon, and others, would proceed shortly to some of the principal towns in the district, to canvass for subscriptions, and make more widely known the very benevolent and humane objects of a society which has already effected, and is effecting, so much good.

DEATHS.

April 2nd, at his residence, Antigua, after two days illness, WALTER MURRAY SEDGWICK, Esq., M.R.C.S., aged 28, eldest son of S. SEDGWICK, Esq. M.D.

April 11th, drowned at St. Thomas's, with three of his crew, from his boat being swamped, and in consequence of giving up an oar to one of his men who could not swim, JOSEPH BUSHMAN, Esq., aged 24, eldest son of Dr. J. S. BUSHMAN, F.R.C.P.E.

At Toronto, Canada, JOHN KING, M.D., aged 52, a native of Tun. On the 8th inst., at the residence of his son, Woodlawn, County Kildare, JOHN WOLSELEY, Esq., M.D., aged 84.

March 18th, at his residence, in Kemper County, Mississippi, U.S., Dr. SAMUEL BELL, in the 62nd year of his age. Dr. BELL was a native of Ireland, and a Graduate in Medicine of the University of Dublin. He moved from thence about thirty years ago, and settled in Anson County, North Carolina, where he resided until the year 1845, when he removed to Kemper. He has left a large family and numerous friends to mourn his loss.

ERRATUM.

At page 126, line 16, second column, for "Urethra," read "Prepuce."

COMMUNICATIONS have been received from Dr. O'Brien (Calcutta); Dr. Dillon Kelly, (Mullingar.) Proprietor of the *Medical Circular*; Dr. Wilks; Mr. Chatto; Dr. M'Dowel; Dr. O'Neill (Lincoln); Dr. M'Gee (Belfast); J. S. P.

PUBLICATIONS RECEIVED.

Gazette Medicale d'Orient.

Irish Quarterly Review.

Fifth Annual Report of the Commissioners for administering the Laws for the Relief of the Poor in Ireland. *Dublin; Thom; 1857.*

Journal für Kinderkrankheiten. 1857. Heft 3 und 4.

Supplement to Thom's Almanac. *Dublin: Thom.*

Revue Medicale.

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CASES ILLUSTRATIVE OF THE BENEFICIAL EFFECTS OF THE OPIUM TREATMENT,

IN INJURIES AND OPERATIONS INTERESTING THE
INTESTINES AND PERITONEUM, WITH REMARKS.

By HENLEY THORP, M.D. F.R.C.S.I.
Letterkenny.

CASE I.

Penetrating wound of abdomen.—Protrusion and strangulation of small intestine.—Enlargement of wound necessary to effect reduction.—Opium in full doses.—Recovery.

On the evening of the 23rd February, 1856, a delicate-looking girl, æt. 10, was conveyed a distance of four miles, on a cart, to the Letterkenny Hospital. The accident for which she sought admission, was a penetrating wound of the abdomen, with protrusion of the intestines. Six hours previously she had been gored by an ox, and the horn of the animal entered the belly on the left side, about half way between the umbilicus and the centre of Poupart's ligament, and through the opening thus occasioned, there protruded a mass of small intestine, of a dusky-red colour, from intense congestion. Having carefully examined the bowels, and ascertained that no injury had been done to them, I proceeded at once to effect reduction in the usual manner; the attempt failing, after the expenditure of much time and patience, I brought about full anæsthesia by chloroform, and again endeavoured to return the protrusion, but without being able to produce the slightest effect, although the fullest relaxation possible of the abdominal muscles was obtained by position, and moreover, the straining efforts of the patient, which previously opposed reduction, were entirely controlled by the chloroform. The deeper seated perforation, which encircled the intestine, was quite circular and unyielding, and was formed on the inner side by the linea-semilunaris, the tendinous structure of which felt particularly rigid. Here I inserted a director, and freed the

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constriction with a probe-pointed bistoury, when the protrusion was returned with the greatest facility. It was now evident, from the relative position of the two wounds—that in the integuments, and abdominal wall proper—that the horn of the animal, after lacerating rather extensively the skin and subjacent cellular membrane, must have glided upwards for some distance over the surface of the external oblique tendon, before penetrating the belly. Having brought together the margins of the superficial wound, by strips of adhesive plaster, and two points of suture, I applied a compress, and confined it with a binder, in the usual manner. The patient, who had vomited frequently on her way to the hospital, now appeared quite tranquil and composed. I administered twenty drops of laudanum, and directed the dose to be repeated after four hours, should the patient, in the meanwhile, not have slept,

24th.—The patient vomited last night, soon after taking the first dose of laudanum; the second, which was given shortly afterwards, remained on her stomach, and she slept soundly till morning. She is now quite free from pain; pulse 99, soft; tongue whitish; stomach tranquil; slight thirst. To have barley water for drink, and half a grain of opium every fourth hour.

25th.—Going on favourably; pulse 86; skin moist; no abdominal pain, tenderness, or swelling; bowels not moved since the accident. Continue the opium, barley-water, and milk; no solid food.

On the evening of this day, the parents of the little girl called at the hospital, and removed her, regardless of all remonstrance. Particular directions, however, were given as to her management at home; they were adjured not to administer castor oil, the favourite remedy for all disasters amongst the poor in this locality; and the half-grain doses of opium were directed to be regularly continued for two days longer. All solid food was prohibited.

26th.—The father of the patient called at my house, and reports favourably; no sickness of stomach or pain in the abdomen; bowels not moved.

✱

Allowed arrowroot, with new milk; continue the opium till the day after to-morrow, and afterwards administer an emollient enema if necessary.

29th.—This day Dr. Cannon, of Church-hill, kindly visited the patient for me; he removed the sutures and dressed the wound. Yesterday the opium was discontinued, and the enema administered, as directed. It was retained but a short time, and did not produce any evacuation; in the morning, however, the bowels had acted spontaneously.

The removal of the sutures was followed by considerable gaping of the wound, which suppurated and healed slowly. To prevent the occurrence of hernia, I directed a compress to be placed over the situation of the injury, and a binder round the belly; these appliances, however, were soon thrown aside; nevertheless, when I last examined the patient, about six months ago, there was not the slightest tendency to any protrusion or swelling in the neighbourhood of the cicatrix.

CASE II.

Perforating wound of abdomen.—Protrusion of large intestine and omentum, with oblique wound of the former.—Opium in full doses, subsequently combined with calomel.—Artificial anus.—Recovery.

On the morning of Wednesday, 30th July, 1856, I was called to the Letterkenny Bridewell, to visit John M'Dermott, a bailiff, under arrest on suspicion of having committed forgery, and who was to have been examined on that day by the magistrates, previous to his committal to the County Goal. Upon entering his room, I found him walking about in the most deplorable state of mental excitement and distress. He at once exposed his abdomen, and exclaimed "See what I have done! Is there any hope for me?" But a few minutes before, in a moment of suicidal phrensy, he had plunged a case-knife into his belly, and he now appeared like a criminal overwhelmed with terror at the prospect of approaching death. The wound, which was two inches and a half in extent, was situated about the same distance below the umbilicus; it was vertical, or nearly so, and corresponded to the linea alba: through it a coil of large intestine, a foot in length, together with a portion of the great omentum, protruded. Having calmed the patient, I proceeded to examine the parts more particularly, and discovered a wound in the gut, about an inch long, through which some feculent matter of firm consistence had already escaped. It was oblique in its direction, did not gape much, nor were its edges or the mucous membrane much everted. In the omentum also, which lay in front of the colon, an opening of the same length existed. Having approximated the edges of the wound in the intestine by one point of suture, I returned it into

the abdomen first, and afterwards the omentum, *bringing out the ligature through the opening in the latter*, and also through the external wound, where it was properly secured. The lips of the external wound were then, in their turn, brought together by two sutures passed merely through the skin, when a compress and roller round the belly completed the dressing. The patient, who was still suffering from poignant grief and fear, was cautioned to remain perfectly at rest in the recumbent posture, and a draught, containing one drachm of laudanum, was at once administered. I again visited him at 10 p.m. He had dozed occasionally during the day; pulse 95, soft and small; skin perspiring; much thirst; no pain in abdomen; pupils contracted; he still appeared greatly agitated and nervous. Repeat the draught, with one drachm of laudanum.

31st.—Patient passed a rather restless night; he dozed at intervals, but started frequently; skin moist; urine scanty; slight headache; tongue white; pupils contracted; pulse 96, small; no abdominal pain or tenderness; bowels not moved; thirst continues. To have barley-water, acidulated with lemon-juice, for drink; and half a grain of opium every third hour.

August 1st.—Throughout yesterday the patient continued in a tolerably satisfactory condition; he also slept well in the early part of the night, but awoke this morning complaining of heat and pain in the belly. Tongue dry and white; pulse 104, small. When the compress and binder were removed, the abdomen appeared retracted, and the recti and other muscles in a state of spastic contraction—rigid as in tetanus. Pressure gave pain over an area of three inches around the wound, the edges of which were red and swollen, and secreted a scanty ichorous discharge. Twenty-four leeches to be applied immediately, fomentations, and a bran poultice. Two grains of calomel and one of opium every three hours.—10 o'clock, p.m. Patient feels easier; less pain in the belly; muscular rigidity and tenderness, same as in the morning; bubbles of gas escape from the wound, the discharge from which also has evidently a stercoaceous odour. The sutures were accordingly removed, and the bran poultice re-applied.

2nd.—Not much alteration in the patient's general condition; he passed a tolerably tranquil night, and scarcely complains of pain; the tenderness upon pressure, however, and the rigidity of the abdominal muscles continue; feculent matter, in small quantity, and gas, escape from the wound. Repeat the application of twenty-four leeches, and continue the pills of calomel and opium.—10 o'clock, p.m. Going on favourably; no pain during the day; tenderness on pressure and muscular rigidity less. Tepid water injected into the rectum, escapes immediately through the wound, which presents a healthier appearance; pulse 96, softer and fuller; no mercurial fetor. Continue the pills.

3rd.—Still improving; scarcely any tenderness of belly; muscles flaccid; pulse 90; gums spongy. Omit the pills. The rectum was again distended with tepid water, which escaped freely through the opening in front, carrying out small portions of feculent matter, and mucus. To have half an ounce of castor oil, with cinnamon water.

4th.—Purgative draught operated freely; there was a copious discharge of feculent matter, through the wound; nothing, however, passed from the rectum but mucus and flatus. Abdomen feels soft, and bears pressure well; pulse 90; mouth sore. From this date until the 29th instant, when the patient was removed to the County Gaol at Lifford, the progress of the case afforded no circumstance of particular interest. The bowels were emptied almost exclusively through the artificial opening, the margins of which, and the surrounding integuments, becoming excoriated and tender, from the passage over them of intestinal discharges, produced much annoyance, which was partially obviated by the application of a solution of nitrate of silver and frequently dusting the parts with absorbent powders. With the view of soliciting the feces through their proper channel, the rectum was daily distended with tepid water, and a compress, supported by a roller round the belly, placed over the artificial anus; these expedients were not found effectual, in consequence of the relaxed state of the bowels favouring the constant discharge of fluid feculent matter, which soiled and polluted everything. This continual diarrhoea I ascertained to have been kept up by large quantities of butter-milk which the patient daily consumed, and which was clandestinely procured, being contrary to my directions. He refused to take medicine in any form, and at length acted in such a manner as to convince me that he was endeavouring to retard his recovery, so as to postpone, as long as possible, the period of his committal to Lifford. As the discipline of the bridge-well was not sufficiently stringent to permit of my treating him any longer with satisfaction, or even safety, I was glad to have the opportunity of getting him removed. The following letter from Dr. Little, contains a brief account of the patient while under his care, at Lifford:—

"MY DEAR THORP,—After M'Dermott's admission into the gaol, my chief attention was directed to the prevention of the constant oozing that was going on through the wound, which, by properly constructed pads, I succeeded in effecting, and in about two months the wound was perfectly closed. He has since then continued quite well, with the exception of occasional attacks of colic, to which, I dare say, he will be subject. He has left the hospital long since, and is at present in his ward, with the other prisoners.

"Yours very truly, in haste,

"ROBERT LITTLE.

"Lifford, 16th May, 1857."

CASE III.

Strangulated oblique inguinal Hernia.—Failure of the taxis.—Operation by short external incision.—Stricture produced by the neck of the sac opposite the lower ring.—Opium in full doses, with calomel.—Recovery.

On the 7th of March last I was requested to visit James Watt, æt. 30, a labourer, constantly employed in carrying sacks of corn, coals, &c. I received the following history of his case:—For several years he has been subject to a swelling, which occasionally descended into the scrotum, but was easily returned into the abdomen by slight pressure with the fingers, until latterly, when the tumor, having grown larger, upon coming down produced sickness of stomach and pain on several occasions, and required greater pressure and force to effect its reduction. The day before yesterday, while heaving a sack of coal, the swelling again descended; it was of unusual bulk and firmness; he felt weak, and immediately rejected the contents of his stomach. The vomiting has since continued at intervals, with thirst, pain in belly, and constipation.

The tumor which occupied the scrotum was obviously a hernia of oblique descent; it lay in front of the cord, and was distinct from the testicle, which was situated inferiorly; it was oval in form, tense, and rather painful when handled. The inguinal canal was also the seat of a swelling, to which an impulse was communicated when the patient coughed, *down to the situation of the external ring only*; below this point no impulse could be felt. When the scrotal tumor was grasped at its lower part, and quickly compressed, the effect of the pressure was perceptible upwards, *precisely to the point where the impulse from above downwards ceased*; and here, at the position of the ring, there was a depression to be distinguished between the inguinal and scrotal divisions of the protrusion. As the abdomen was rather tumid and painful when pressed, it was evident there was no time to be lost; accordingly, having brought the patient fully under the influence of chloroform, and failed, after a fair trial of the taxis, to reduce the swelling, I proceeded to operate without further delay.

Believing the case to be a favourable one for Petit's operation, I commenced by making a short incision over the external abdominal ring, where the symptoms already detailed made it obvious the constriction was to be found. After dividing the superficial structures in the usual manner, the aponeurosis of the outer oblique muscle came into view, and the inter-columnar fascia was seen descending from the borders of the ring. Having slit up this latter with a probe-pointed bistoury, conducted on a director, and the incision having failed to release the strangulation in the slightest degree, I next divided in succession the cremaster

muscle (the fibres of which were strongly developed), and the delicate membrane called the internal spout-like fascia, which, although thin, was quite distinct, but difficult to be distinguished and separated from the sac, the stricture was now evident, both to the touch and sight; it felt firm and thick, and looked like a tight cord encircling the protrusion. As the sac evidently contained scarcely any fluid, and the limited extent of the external incision prevented me from opening it at its lower part, this proceeding required much caution; a small perforation, however, admitted a director, when the bistoury made the requisite division of the dense structure into which the serous membrane was converted. The protrusion consisted exclusively of small intestine; it presented a good deal of capillary vascularity, and was coated slightly with recently effused lymph. Slight pressure effected its reduction, and it went up suddenly, and with a gurgling noise, when a serous fluid, in considerable quantity, gushed out of the abdomen. I had now an opportunity of examining more particularly the neck of the sac, where the strangulation existed; its structure was changed into a firm gristly material, that formed a narrow, but thick and unyielding circular band, the peritoneum above and below which appeared perfectly healthy. A couple of points of suture served to close the incision through the skin, over which a compress of lint was placed, and secured by a spica bandage. The necessary directions as to posture, diet, &c., being given, the patient was ordered one grain of opium and two of calomel every third hour.

8th.—This morning the patient is cheerful, and expresses himself as being quite relieved. He has had no vomiting since the operation, nor pain in the belly. Pulse 86, soft and regular. Slept well during the night; skin perspiring. Pills of calomel and opium, to be continued every third hour.

9th.—Slept very much since yesterday, both by day and night; when awake drank freely of whey, which he greatly relished. Abdomen not tender, but rather tympanitic; bowels not moved; urine moderate in quantity; no mercurial fetor. Continue the pills every fourth hour.

10th.—Mouth slightly affected; pulse 90, in other respects the same as yesterday. From the occasional discharge of flatus per anum, patient believes that the bowels are about to act. Omit the pills of calomel and opium.

11th.—Bowels moved yesterday; sutures removed; wound suppurating; poultice applied. Ordered a draught of castor-oil and tincture of rhubarb; to have chicken-broth and bread. From this date onwards the patient's progress to recovery was uninterrupted. The incision suppurated deeply, and was slow in healing, but at length closed up and cicatrized.

REMARKS.

Some of the most important principles of medical science have grown into maturity out of a solitary observation or fact, and many valuable precepts have originated in the casual discovery of an unsuspected virtue in some common remedy. In the year 1822, in the old Meath Hospital, Dr. Graves prescribed opium in large doses for a poor woman suffering from peritonitis, occasioned by the operation of paracentesis; and although the case seemed hopeless, to his great astonishment the patient recovered. Subsequently he published, in conjunction with Dr. Stokes, in the fifth volume of the *Dublin Hospital Reports*, their conjoint experience of the opium treatment in cases of peritonitis, the result of rupture or perforation of the stomach, intestines, uterus, &c.; and the change which has taken place in these countries within the last quarter of a century, in the surgical treatment of various accidents, and operations involving the peritoneum and intestines, may be fairly dated (although our friends across the channel be slow to acknowledge the fact) from that most valuable communication. Let any one who entertains a doubt upon the subject take up the last edition of *Cooper's Surgical Dictionary*—a work which may be supposed to expound the views and practice of the best English surgeons of the day—or indeed any publication of the same date professing to treat of the subject under consideration, and consult the practical remarks of the writers, and no allusion whatever will be found to the remedial powers of opium administered in large doses, in injuries of the abdomen and herniæ. In fact, the principle of controlling the peristaltic action of the intestines, and of suspending as far as possible the functions of the chylo-poietic viscera generally, after operations and injuries of the abdomen, by large and repeated doses of opium, and diminution of the ingesta to the smallest possible quantity consistent with life, has but very recently been acted upon in surgical practice to an extent commensurate with its great importance. Not many years ago it was the common custom (supported by a no less high authority than Sir A. Cooper) to administer, after the operation for strangulated hernia, enemata, castor-oil, and even stronger purgatives, with a view of restoring as soon as possible the functions of the intestinal canal. Different views, however, are now pretty generally entertained upon this subject, and surgeons are not so very solicitous about the immediate, or even speedy, action of the bowels, unless, indeed, under special circumstances.* The more rational prin-

* In cases of chronic strangulation, or incarceration and other cases, where symptoms of obstruction continue after the operation, and there is reason to believe that these symptoms depend upon inaction of the bowel from over-distention or frequent accumulation, stimulating enemata and purgatives are indicated. It is unnecessary to observe that the opium treatment, under these circumstances, is inadmissible, at least in the first instance.

ciple of promoting the quiet of these viscera, and allowing them gradually to recover their functions, rather than prematurely excite their peristaltic action by stimulating cathartics, is the principle now generally acted upon by the best practitioners. Thanks to the Irish school of medicine, through her practical energy the doctrines of abdominal pathology in their most important relations were modified and emended. I attribute the successful termination of the cases just detailed chiefly to the free use of opium, and the avoidance of all causes calculated to promote the functional activity of the organs concerned. In Case No. I. opium was the only medicine used; in No. II. it was necessary to combine the same substance with calomel, on the supervention of symptoms of peritoneal inflammation; and in the third case—that of strangulated hernia—the two medicines were given from the outset, as it was evident at the time of the operation that inflammation had already commenced. In no disease is the wonderful power which calomel possesses of controlling inflammations of serous surfaces more potently displayed than in peritonitis. It may truly be said to be the *sine qua non* of treatment, the sheet-anchor of success; but some difference of opinion exists as to the expediency of exhibiting it immediately in recent injuries of the abdominal cavity and its contents. Many practitioners suppose that when given as a prophylactic, its therapeutical influence may interfere with those salutary processes of an adhesive character, which are essential to the patient's safety; they consequently delay its administration until symptoms arise indicative of physiological actions exceeding their just limits, and assuming a spreading or pathological tendency. Others exhibit it from the commencement, believing that all penetrating wounds of the abdomen are almost of necessity followed by a degree of inflammatory action exceeding the limits of safety, and which, if not anticipated by ptyalism, may peril the life of the patient, before the mercury can be introduced into the system in sufficient quantity to arrest its progress. My belief is, that in these cases the opium treatment may be relied on in the first instance, or for the first twenty-four hours; after which mercurial inunction may be commenced as a precautionary proceeding. In the meanwhile the patient must be attentively watched, so as to discover the earliest indication of peritoneal irritation; and should there arise the slightest symptom of a threatening nature, calomel ought to be combined with the opium, *continuing the latter in full doses* until ptyalism is established. Thus the patient derives all the benefit, both immediate and prospective, that art is capable of affording. By opium we promote the repose of the injured parts and organs, and tranquillity of the system generally, and so diminish the spreading tendency of irritation over the continuous serous surface; it should therefore be given at once, and repeatedly, until all danger is at an end. It is the

true *prophylactic*; but when decided symptoms of inflammatory action are impending or present, calomel is the *remedy*. Mercurial inunction alone cannot be depended upon; it is too slow and uncertain a method to overtake the rapid progress of one of the most destructive of all inflammations. Of course these remedies are not to be employed to the exclusion of local and general bleeding, according to the circumstances of each case—rest, and other necessary measures. The remarks just made only apply to recent injuries of the abdomen and its contents; in strangulated hernia the case is different: here opium requires the mercurial to be combined with it from the commencement, as the peritoneum and intestines will generally be found, at the time of the operation, in a condition at least of hyperæmia, if not of absolute inflammation.

The surgical management of the wounded intestine, in Case No. II., requires a passing comment. To one acquainted with the literature of the subject, the conflicting views of the most accredited authorities on this point, are most embarrassing in practice. Scarpa eschewed ligatures altogether, returned the intestine into the abdomen, placing its wound in correspondence with that in the abdominal wall, trusting to the mutual pressure of the latter and its contents, and to the lymph, which is quickly effused, as the most efficient barriers against extravasation. Travers, on the contrary, unites the wound in the intestine by continuous suture, and having cut short the latter, returns the former into the abdomen, and closes also the external wound. I can only say that I avoided both extremes, and endeavoured, as far as possible, to obtain the advantages of the two opposite plans. The single ligature which I employed served to close the short opening in the colon, and also to preserve its relation to the parietal wound and to that in the omentum; if adhesion occurred, very well, otherwise it would be easy to cut the interrupted sutures which united the integuments, and were intended to give them also a chance of healing by the first intention. Adhesive inflammation did fail, to the extent of confining the intestinal contents: the latter slowly oozed out, but the speedy removal of the sutures from the cutaneous structures, allowed of the free egress of feculent matter, and prevented extravasation.

There are two circumstances worthy of notice in Case III. First, the diagnosis of the situation of the stricture, previous to the operation. This was established by the division of the protrusion into two portions, an upper, occupying the inguinal canal, and a lower, the scrotum. To the inguinal division an impulse was communicated by coughing down to the divisional sulcus at the outer ring; no constriction, therefore, could have existed above this point; and as compression of the scrotal portion produced an impulse up to, but not above the groove referred to, it followed that the

stricture must have existed at this point, that is to say, where the two impulses, that from above downwards, and below upwards, united or ceased. Secondly, as to the existence of the stricture in the neck of the sac—this fact, so far as one case can have a weight, is corroborative of the views of Dupuytren, and should make us cautious when performing Petit's operation, not to *push* the intestine into the abdomen still strictured by the sac, an accident most likely to happen when the hernia is small, and the stricture situated at the internal abdominal ring.

ON BONY CYSTS OF THE LOWER JAW.

By ROBERT ADAMS, M.D.

Surgeon to the Richmond Hospital.

(Continued from page 116.)

CASE II.

Multilocular Bony Cyst of the lower Jaw, with fluid contents.—Amputation of the diseased portion.

At a late meeting of the Pathological Society,* I detailed the history of a case of bony cyst of the lower jaw which had *solid* contents; and gave an account of the operation had recourse to for the remedy of this disease. To-day it is my intention to follow up the subject of bony cysts of the lower jaw, by the relation of a case in which the contents of the cyst were *fluid*. Although it is now some years since the subject of this observation was under my care in the Richmond Hospital, yet, as our Museum contains drawings and casts showing the condition of the jaw at the time of this patient's admission, and as the portion of the amputated bone, as well as drawings exhibiting the recent appearances which the bony cyst presented, have been preserved, I feel I can lay the case as satisfactorily before the Society to-day as if it had occurred but yesterday; and here let me observe, that if, on the one hand, this case may fail to excite the degree of interest which usually attaches to recent examples of disease and the operations undertaken for them; on the other hand, the report of it should, in my opinion, be considered as more valuable because many years have elapsed since the amputation of the morbid portion of the lower jaw was performed, and there has been no return of the disease, a circumstance affording us the best proof that the nature of the case was benign.

William Dunne, æt. 36, a carpenter, native of the North of Ireland, was admitted into the Richmond Hospital, on the 14th of December, 1842, under my care. He sought advice on account of a tumor, the size of a hen's egg, which occupied the right side of the body of the lower jaw, extending from a point behind the socket of the se-

cond incisor, near to the alveolus of the third molar tooth; in fact the swelling, viewed externally, seemed to extend from the symphysis near to the angle of the lower jaw. It projected but little to the inside of the bone, but externally it caused considerable prominence of the lower part of the cheek. This tumor, which was almost entirely covered by the mucous membrane, was uneven as to its surface, and under firm pressure proved very elastic. The most prominent points were the softest. The first molar tooth had been removed, and its socket was filled up to the level of the adjoining teeth by an extension of the tumor, which was here covered by healthy mucous membrane. The second molar tooth and the two bicuspsids were loose. He suffered almost constantly from a dull aching pain in the tumor, which seemed to extend down to and include the lower margin or basis of the jaw. His general health was excellent. He stated that he felt as if the affected part were weak, and it seemed, from his own account, as if an instinctive consciousness of this weakness rendered him cautious in chewing solid substances; his words were, "that he felt as if the bone would snap if he were to attempt to crack any hard body with his teeth." The patient stated that the disease was of three years' duration, and that he knew of no cause to which he could attribute its origin; that it first showed itself as a firm tumor, of small size, on the outside of the gum, near to the first molar tooth. For some time after its first appearance the disease progressed but very slowly; but after the expiration of eighteen months the first molar tooth became loose, and the patient now, for the first time, experienced a painful aching sensation in the jaw. The loose tooth was extracted, and the tumor continued to extend itself; subsequently the most prominent part of the swelling was punctured, and a thin serous and bloody fluid was given exit to, with some relief to the patient. The opening thus made did not close for some time, and the patient could by pressure empty the cavity of the swelling of its thin serous contents, observing, at the same time, a "yielding of its walls, giving him the idea as if he were pressing on a thin shell." One year before admission, he observed the tumor began to project slightly inwards towards the tongue. The teeth adjacent to the one which had been removed now became loose, and the aching pain more constant and more severe.

Finding the disease thus increasing, he consulted my friend Dr. McDowell, of Monaghan, who advised him to place himself under my care in the Richmond Hospital, which he did accordingly. At a full consultation, the removal of the portion of the lower jaw, which included the tumor, was decided upon, as the only operation suited for this case, which was accordingly performed by me on the morning of the 22nd of December.

The second incisor and the third molar teeth, on the right side, were removed, to leave space

* The second portion of Mr. Adams's observations on Bony Cysts of the Lower Jaw is inserted in the form in which he communicated it to the Pathological Society.

for the action of the chain-saw on each side, beyond the limits of the disease. The incisions through the lip by the knife, and through the alveolar sockets by the chain-saw, were performed in a manner similar to that which many here present have seen lately adopted in the former case of Macdonnell; but, as the tumor was smaller, the operation was by so much the less severe in this case of Dunne, which we are here describing.

Considerable constitutional disturbance immediately followed on the operation, which had been necessarily a very painful one. The most prominent symptoms, three hours after it, were—extreme mental depression and despondency, frequent sighing, prostration of strength, with a weak, slow, and intermitting pulse. He had no sleep on the night succeeding the operation, but sat up constantly in bed, from a feeling of suffocation being induced whenever he attempted to lie down. Drinks were given to him (in the usual manner after such an operation), conveyed through a gum elastic tube.

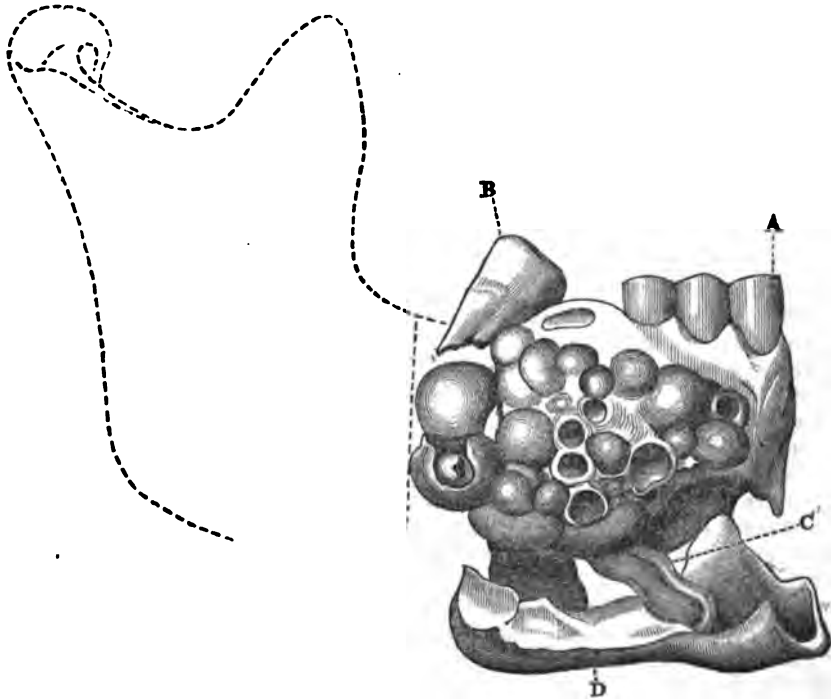
On next day, Friday, the same nervous symptoms were present, but in a mitigated degree. Anodynes had procured him some rest; but it was not until Saturday, the third day, the effects of the shock of the operation had completely passed away. The incision through the lip united by the first intention, and was healed on the third day, when the hare-lip pins were withdrawn; the remainder of the wound suppurated. In a week

after the operation the patient left his bed, and his former cheerfulness returned, and from this period the progress of the case towards complete recovery was very rapid; in four weeks the wound was completely cicatrized, with but little deformity.

February 9.—Six weeks and a half after the operation he felt himself so perfectly recovered that he left the hospital for the country.

The portion of the lower jaw which was removed was about two inches in length, and measures an inch and a half in depth. The tumor (as seen from this cast taken of it) had somewhat of a globular form, but projected more on the external side, towards the cheek, than internally towards the mouth; it was elastic, and yielded to the pressure of the fingers. On even the external view of the portion amputated, it was evident it consisted of a multilocular cystic tumor, for the mucous membrane which covered it was here and there raised up into small, little-rounded eminences, the size of peas; some were double this size; a few were of a purple colour, a hue which dissection proved to have been derived from coagulated blood and coloured serum, which some of the thin transparent bony cells contained. When the mucous membrane was removed, and the whole tumor subjected to further dissection and maceration, it was found that the basis (fig. 1, D) of the lower jaw (a thin shell of which alone remained), was the only portion of bone which had not been much

FIG. 1.



A. Canine. B. Second molar. C. Anterior portion of dental nerve. D. Remains of the basis of horizontal branch of jaw excavated on its upper surface, on which lay the tumor.

The dotted lines are suppositions, introduced merely to give an idea of the relative position of the healthy and morbid portions of the lower jaw.

encroached upon by the disease. The tumor itself was found composed of bony cells, of a texture as fine as those of the ethmoid bone.

The cells generally were of such a size that each might be capable of receiving within it a garden-pea. They communicated with each other, and amounted to no less than twenty-six in number. They were all lined by a pulpy, very red, vascular membrane (as delineated in the drawing I present), and contained an albuminous fluid, tinged of a reddish colour, apparently from blood held dissolved in it.

The inferior dental nerve (Fig. 1, C) and vessels were found placed beneath the lowest part of the cystic tumor; indeed, the superior wall of the dental canal had been absorbed, and was thus converted into a gutter or groove, in which the dental nerve lay. The branches which had run from the trunk of the nerve to the lower point of the fangs of each tooth could not be traced through the morbid mass, and were most probably destroyed. The roots of the teeth were widely separated from the nerve by the interposition of the whole of the cystic tumor. In short, the trunk of the inferior dental nerve, exposed in its canal, seemed to have been compressed between the lowest part of the cystic tumor which overlaid it, and the hollow of the upper part of the basis (Fig. 1, D) of the lower jaw, a remnant of which still existed.

There were two circumstances in the history of the case, we may remember to have been much dwelt on by the patient himself, for which this part of the anatomical examination of the disease suggests to us a plausible explanation:—

1st. The instinctive fear the patient had that the bone should give way when he was chewing a hard substance, might have had a material foundation in the very slender condition and reduced state the horizontal ramus of the jaw had been found in; and secondly, that the dull aching, so much complained of, was due to the lesions the dental nerve and its branches were proved by dissection to have been subjected to.

In concluding this account of the case, it may not be unprofitable here to observe, that as we now know that this was a case of bony cyst of the lower jaw, of a nature clearly benign, it should be a subject for reflection with us, whether we might not have attempted the removal of the bony cyst by means of the knife and the gouge, and without using the saw, or interfering with the remnant of the horizontal ramus of the lower jaw, with which the bony cyst was connected below; for my part, however, I feel persuaded, that had we removed the tumor merely, without having had recourse to the amputation of a portion of the basis of the lower jaw itself along with it, that we should have been ultimately disappointed; for it is manifest, that any operation for the removal of the tumor alone could not have been effected without the necessary sacrifice of the dental nerve and accompa-

nating vessels, lesions almost certain to have been succeeded by necrosis, or caries of the jaw.

As the local disease was far advanced, I believe it was better for the patient that he should have undergone at once the more complete operation, than that he should have been subjected to the milder expedient, which might not have proved so effectual, of having the bony cyst gouged out of the jaw, an operation certainly less severe than that actually performed, but one which, equally with it, would have involved the sacrifice of the alveolar border of the right side of the jaw, which had contained seven of the teeth; that is to say, all those at this side, from the second incisor to the last of the molars inclusively.

In conclusion, I may here mention that I saw Dunne nine years after the operation, and he had no return whatever of the disease, nor was there anything singular in his appearance. The notes I have entered in my case-book on this occasion are:—"The amount of deformity which in this case remains after the operation is really very trifling; it is true that the separated portions of the lower jaw, although reunited to each other by a firm ligamentous tissue, do fall in somewhat, so that when the mouth is fully shut the lower teeth do not exactly meet those of the upper jaw as formerly, but rather pass behind them. Scarcely any trace of the vertical incision through the lip can be seen, and the remainder of the cicatrix, shrunk in below the ordinary site of the basis of the lower jaw, is invisible.

The patient does not complain of any inconvenience, except that he must use only one side of the jaw in mastication.

Mr. Cusack, in a very valuable memoir, written many years ago, on amputations of portions of the lower jaw,* among other examples of disease of this bone, has given the case of a woman named Catherine Kenny,† aged 30, from whom he removed about one-half of the lower jaw, sawing the bone at the symphysis, and disarticulating it on the right side. Referring to the volume in question for the history of this case, I may here observe, that, as Mr. Cusack has omitted to give an account of the dissection of the amputated part in this interesting case, I may, with his permission, supply this deficiency, which I am now enabled to do from having carefully examined, anatomically, the amputated part, and procured a drawing of it by Connolly, which I lay before the Society.‡

I consider the specimen valuable, as it admirably illustrates the subject we are here discussing, namely, the pathological anatomy of bony cysts of the lower jaw with fluid contents.

The portion of bone removed in this case of

* Dublin Hospital Reports, vol. iv.

† Loc. cit. page 29.

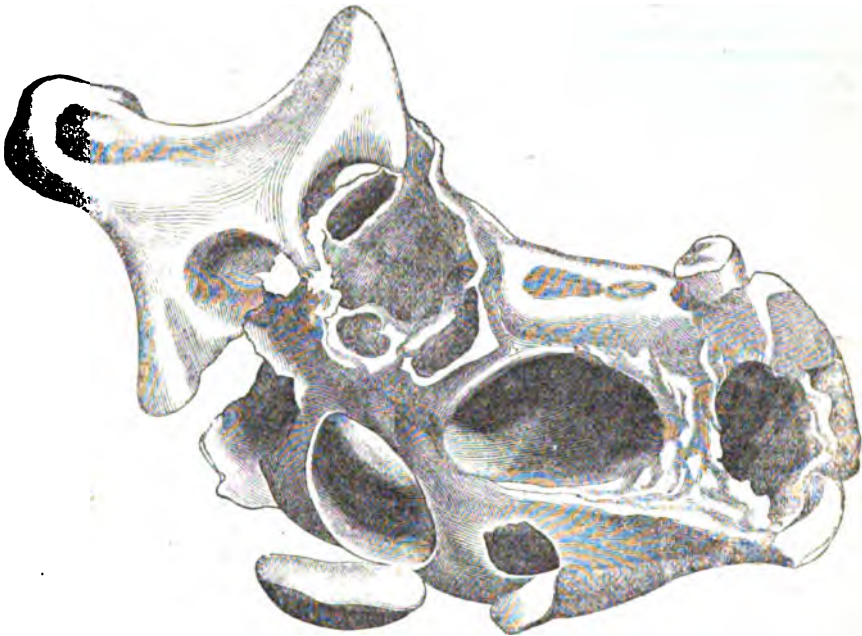
‡ The specimen was preserved in the museum attached to the Medical School in Park-street, in this city, which museum has been transferred to the Queen's College, Belfast.

Catherine Kenny comprises the entire right half of the lower jaw; the horizontal ramus of the bone is expanded into an oblong hollow shell (Fig. 2) with bony walls. This bony shell or cyst, we find, is, as to its interior, subdivided into many cells of various sizes, which are all lined by a fine polished membrane, and communicate freely with each other;—in a word, the amputated part proved to be a multilocular bony cyst, with fluid contents.

The cells contained a transparent albuminous fluid, the gradual formation and accumulation of which had expanded the bone. This appearance is well represented in the adjoining woodcut—(see Fig. 2).

I shall elsewhere continue the consideration of bony cysts of the lower jaw, by making some observations on the history, symptoms, &c., and on the surgical treatment of this disease.

FIG. 2.



Multilocular bony cysts of jaw, with fluid contents.

LECTURES ON DISEASES OF THE STOMACH.

By DR. LEES,

Physician to the Meath Hospital, Lecturer on Practice of Medicine.

PAIN IN THE STOMACH; GASTRODYNIA.

SYMPTOMS; CAUSES; DIAGNOSIS; TREATMENT.

Pain in the stomach is met with under a variety of circumstances, and in very different, or even opposite, conditions of that viscus. Thus it occurs not only as a symptom in its inflammatory and organic diseases, but it may be equally severe when sympathetic of other diseases in remote parts of the system, as in females affected with uterine disorders; or in even a still greater degree in its mere functional and nervous derangements, in which we cannot detect any appreciable alteration of structure. To these latter forms the term *gastrodynia* is usually applied; and I will therefore consider them under this term, as distinct from the former. Dr. Abercrombie states, that "pain in the stomach occurs in practice under *four* different

forms, which seem to imply important differences in the nature of the affection." 1st. "Pain occurring when the stomach is empty, and relieved by taking food." He considers that this form depends on some degree of acrimony of the fluids of the stomach itself, and is generally relieved by absorbent and alkaline remedies, such as aromatic spirit of ammonia, or magnesia. 2nd. "Pain occurring *immediately* after taking food," and which he thinks is connected with chronic inflammation, or increased irritability of the mucous membrane of the stomach, and should be treated by remedies suitable to that state. 3rd. "Pain beginning from two to four hours after a meal." This, he thinks, is seated in the duodenum, and connected with inflammatory action or morbid sensibility of its mucous membrane; but as it is often accompanied by pain and tenderness on pressure, in the right hypochondrium, it is often mistaken for disease of the liver. He recommends the sulphate of iron in doses of two grains, combined with one grain of aloes and five grains of aromatic powder, taken three times a day; also lime-water, opiates, and bismuth, combined with rhubarb. Dr. Watson considers that this form of pain is caused by acidity in the primæ

vix, and he prevents it by directing the patient to take a small quantity of alkali in some aromatic water, immediately after his dinner, or a cup of warm tea, by which the acid is diluted. The fourth form of pain in the stomach "occurs at uncertain intervals, in most violent paroxysms, with a feeling of distention, much anxiety, and great restlessness." Dr. Abercrombie considers that it depends on over-distention of the stomach, or may be sometimes seated in the arch of the colon, and is best relieved by carminatives, or by a strong injection. Dr. Watson says that hydrocyanic acid is a most valuable remedy in these cases, also opium; but you should never neglect the use of external applications, as you will give great relief by very hot stupes, particularly if sprinkled with turpentine; or apply a large mustard poultice over the epigastrium. Persons of a gouty habit are very liable to be attacked with this kind of pain, which in them is generally best treated by stimulants and opiates, as brandy and laudanum, with sinapisms applied to the epigastrium and feet; but you should remember that there is a form of inflammatory gout which occasionally attacks the stomach with violent pain, attended with fever, and demands an opposite line of treatment. In all these patients great attention should be paid to the diet, which must be adapted to each particular case, as what will suit one may not agree with another; but as a general rule, the food should be given at regular periods, in small quantities at a time, and of a plain, light kind, easily digestible.

I will now proceed to consider the true gastrodynia, by which term I mean an affection of the nerves of the stomach, not connected with any change of structure, but characterised by violent attacks of pain coming on in paroxysms, sometimes induced by taking food or drink, but frequently coming on suddenly, without any assignable cause, and often ceasing in a similar manner. The character of the pain varies: some describe it as cutting or stabbing, others as a tearing or burning pain; some say they feel as if the stomach was about to burst, others as if it was constricted by an iron band; and some say they feel as if an animal was creeping inside of them. The pain is seldom continuous, but intermits and recurs again; is not excited nor aggravated by pressure of the hand, but is often relieved by it; and though often so severe as to make the sufferer assume every position, in order to get relief, and even unloose their clothes or stays, so as to take off pressure from the epigastrium, yet it is rather owing to morbid irritability of that part than to any actual tenderness. The pain often radiates round the sides, up the chest, to the shoulders; and sometimes, in females, there is great tenderness in the dorsal region, and pressure on this part aggravates the pain in the stomach. They are often in a state of great anxiety, and sometimes there is violent pulsation in the epigastrium; but the pulse is generally quiet, and there is no fever. The pain

may be very violent, and then cease suddenly in a few minutes, leaving the patient nothing the worse, or may last some hours, and then cease gradually, but often leaves the patient tired and exhausted, with a sensation of soreness at the epigastrium. The termination of the paroxysm is sometimes marked by copious eructations of gas, which come up without any effort, and give great relief; in other cases there is a flow of water from the stomach, either insipid or very acid; and in some cases there is vomiting of mucus. The appetite is variable, sometimes increased, at other times diminished, often not affected; while in some cases, particularly in chlorotic females, the most indigestible things are frequently wished for, and there may be even perversion of the natural appetite. Thirst is seldom complained of, and the tongue is often natural in appearance, but may be large and moist, or thickly coated with a whitish fur. They often suffer from headache, costive bowels, irritability of temper, and become hypochondriacal, with all the symptoms of aggravated dyspepsia; but in other cases, though the paroxysms of pain may be very severe, yet there may be no other symptom of dyspepsia, and the patient may digest the food well, and be in good condition. This difference in the symptoms may be accounted for by a difference in the form of the disease. One form, which we may term functional, appears to be caused by an excessive secretion of unhealthy mucus, which deranges and oppresses the stomach, and is often met with in the lower classes of society, chiefly caused by errors in diet or abuse of stimulants; but prolonged fasting, or drinking large quantities of diluents—as tea, or even water—may have the same effect. Mechanical causes—such as injuries, certain sedentary professions or trades, in which the body is bent up or stooped forward, particularly if after meals; pregnancy also, or any tumor in the abdomen—may cause it, by making pressure on the stomach, and thus interfering with its functions. Certain medicines, also—as the preparations of iodine, balsam of copaiba, quinine, and iron, if continued too long—may have the same effect; so that their use ought to be suspended for a short time occasionally. It is this form of the disease which Dr. Barlow has described, in an excellent article in the *Cyclopædia of Practical Medicine*; but I think he is wrong in applying to every form of the disease his pathology of gastrodynia, "which assigns the spasmodic pain to the presence of offending mucus, and the efforts of the stomach to get rid of it."* The second form, which I will term symptomatic, is essentially a neuralgia; and though very similar to the last form, as regards the pain, yet it differs in its causation, and in its being unaccompanied by any other symptom of dyspepsia. This form of gastrodynia may depend on many different causes. 1st. Disturbance of the nervous system—as anxiety, anger, fear, hysteria,

* Art. Gastrodynia, p. 329

over-study, particularly if after meals. 2nd. Alteration in the quality of the blood—as in anæmia, chlorosis, purpura, scurvy. 3rd. Hæmorrhages. 4th. Syphilitic, mercurial, paludal, and gouty cachexia. 5th. Diseases in other parts of the system. 6th. Venereal excesses or masturbation in either sex. 7th. Worms. 8th. Hereditary influence. 9th. Sex, as it occurs more frequently in females, particularly in those of a sedentary habit, or subject to depressing influences, either mental or bodily. 10th. Lactation in delicate females, especially if prolonged.

The differential diagnosis of this disease is of great importance for the prognosis and treatment. It is most likely to be confounded with—1st. Simple chronic ulcer of the stomach, as it occurs in much the same class of patients, and the character of the pain is very similar in both; but the aspect of the patient, the history of the case, the irregularity of the attacks of pain, being often quite independent of food or drink taken into the stomach; but above all, the absence of vomiting of pure blood, or of coffee-ground matters, will generally help us to decide; though in some cases where these symptoms are absent, the diagnosis is sometimes very difficult, as I experienced in the case of a female who was under my care in the Meath Hospital, and in whom the paroxysms of pain were attended with great nervous depression, and tendency to collapse, very similar to a case of perforation of the stomach which had occurred some time previously in the same ward. 2nd. Calculus in the cystic or hepatic ducts, or in the gall-bladder, may simulate it; but the severe nausea and vomiting will generally enable us to make the diagnosis. 3rd. Chronic gastritis; but the absence of pain on pressure (though the spontaneous sensation of pain may be very severe), the irregular course of the disease, its intermissions, and the character of the urine, which is rather anæmic than inflammatory, will generally assist us. 4th. Cancer; but the absence of the peculiar cachexia, the emaciation, the non-existence of tumor, or of coffee-ground vomiting, will guard us from such a mistake. Dr. Budd is of opinion, that if the pain depends on organic disease, it is more severe soon after meals, or when the stomach is full; but if it is the result of functional disorder, it will only occur when the stomach is empty, and will be relieved by food; but this rule does not hold good in even a majority of cases, though attention to it is of great importance with regard to treatment, as in the first class of cases the diet should be light, easily digested, and our efforts directed to relieve irritation; while in the second class of cases, sedatives generally relieve the pain.

Gastrodynia is a disease of youth and adult life, but seldom attacks before puberty, and is generally curable, though it often continues a long time, and is very liable to relapse, particularly in persons of an irritable and nervous temperament, or in those subject to neuralgia in other parts of the body. There is no disease for which a greater

number of remedies have been proposed, than for gastrodynia, and among these narcotics and sedatives hold a high place; but never commence the treatment of a case without having ascertained (as far as you can) to which of the forms above described it belongs, and then be regulated by the cause. If you are satisfied that there is an unhealthy secretion of mucus by the stomach, you should try to get rid of it, and correct the condition of the mucous membrane which secretes it. Emetics of sulphate of zinc or ipecacuanha are occasionally useful, but in most cases they are not necessary; and you may commence the treatment by two or three purges of calomel with compound colocynth pill at night, followed by neutral salts with magnesia in the morning, so as to act well on the bowels, the discharges from which are generally dark, fetid, and slimy; and you must first improve this condition before you can expect any real change for the better. You may then give an alterative dose of blue pill or calomel every second or third night, followed by a saline aperient in the morning. If a costive state of the bowels persists, Dr. Barlow advises four grains of colocynth with two of henbane every night, and the daily use of an ounce of the following cordial saline mixture, of which he speaks very highly:

R. Sodæ subcarbonatis, ℥iiss.
Aque puræ, ꝑviiss.
Acidi sulphurici diluti, ʒss.
Confectionis aromaticæ, ʒiiss.
Spiritus menthæ piperitæ, m. xii.

Great attention should be paid to the diet, which ought not to be too farinaceous or very liquid. Commence with good chicken-jelly or beef tea, but get them to eat some solid tender meat as soon as you can, and for drink allow weak brandy and water. Bismuth in doses of five or ten grains, either plain or combined with magnesia, often acts well; so does calumba combined with soda. These are also the cases in which nitrate of silver has often given great relief. You may commence with a quarter of a grain three times a day, combined with aloe or extract of gentian, and let it be washed down with a little water, either cold-boiled, or tepid, or warm, according to the wishes of the patient. In some cases patients complain that any cold drink causes pain, so that you must give them even their medicines in a warm menstruum. In the symptomatic form of gastrodynia, the first object is to relieve the severe pain; and for this purpose you must have recourse to the various narcotics and sedatives, the preparations of opium, morphia, belladonna. Prussic acid combined with soda or bismuth often gives great relief; so does conium and creasote. Nervous medicines are sometimes useful—as valerian, camphor, assafoetida. Dr. Aquila Smith informs me that he often gives immediate relief by making the patient eat a few blanched sweet almonds. The preparations of iron and bark are used as preventatives. Ves-

cation over the epigastrium, and dressing it with morphia, often gives relief. The late Dr. Graves had a high opinion of stramonium in this affection; he also advised friction over the dorsal vertebrae with a stimulating liniment; and Dr. Law informs me that he often applies tincture of iodine to the spine with good effect. The diet should be tonic and substantial; in most cases meat and wine may be given. Great attention should be paid to the functions of the skin; tepid bathing, shower-baths, sea-bathing, and plenty of exercise in the open air, should be persevered in. These patients should be freed as much as possible from care, business, or study. Make them sleep on a mattress, in a well-ventilated room; give up tea, coffee, smoking, snuff, and every habit that can debilitate the nervous system; get them to mix in society; but above all things, if they can afford it, send them to the country, or to travel, or to some of the watering-places; and always endeavour to inspire hope of a certain cure, and confidence in the means, as there is a great tendency to hypochondriasis in all these cases.

CASE OF EXCISION OF THE METATARSO-PHALANGEAL ARTICULATION,

(Read at the Surgical Society, April 4, 1857, by *Saml. A. Cusack, F.R.C.S., Resident Surgeon of Steevens' Hospital, and late H.M. 47th Regiment.*)

A good deal of attention having been given, of late, to the subject of military surgery, I think it may be interesting to exhibit to the society a case in which conservative surgery was practised with great success during the late campaign.

On the 20th of September, 1854, a few minutes after the 47th had crossed the Alma, a sixteen-pound howitzer shell, from a battery on our left front, fell about twelve yards in rear of No. 8 company. It exploded almost immediately, and wounded several of our men, one of whom, Sergeant Henry O'Neill, was struck by a splinter of it in the sole of the left foot, as he was in the act of lifting it from the ground. He staggered a few paces, without being aware that he was severely injured, and fell. I was engaged attending to some other men, whose cases were more urgent, and did not look to him for 20 or 30 minutes after the accident had occurred. When I had removed his boot, I found that a fragment of shell having struck him on the ball of the great toe, had completely divided the soft parts on the inner two-thirds of the sole of the foot, and become impacted in the metatarso-phalangeal articulation.

On extracting the splinter, I found that the extremities of the bones forming the first, second, and third of these joints were much comminuted; the fourth joint was merely opened; while the fifth (that of the little toe) was intact, as were also the soft parts on the dorsum of the foot. Such being the case, I had the option of amputating at

the seat of injury, leaving the dorsal integument for a flap; of performing the operation recommended by Hey; or of excising the joint, and leaving the parts in a favourable state for ankylosis to take place. Knowing him to be a healthy man, I selected the last course, in hopes of his having a more useful foot. As the wound gaped widely, I had no difficulty in using a metacarpal saw, to cut off the distal end of the first metatarsus, as well as the proximal extremity of the corresponding phalanx. The other broken extremities were easily reduced to a level surface, by means of a bone-forceps. A small artery which was bleeding when I came to him I also secured; and having closed the wound with sutures and a bandage, I had him carried to the rear, and sent on board ship the next day. I had no opportunity of hearing anything further of him until yesterday, when he applied to me at Steevens' Hospital, as an out-patient, for another ailment. He tells me that the wound closed up in about four months. The parts are now firmly ankylosed together. There is some little shortening of the inner side of the foot, which is also slightly flattened and everted from the division of the plantar fascia and tendons; but he has very fair use of the limb; certainly more so than if any other operation had been performed.

A cast of the foot was exhibited to the society. The man himself was also in attendance, and was examined by several of the members.

ANEURISM OF THE AORTA, FATAL FROM OPENING INTO THE RIGHT PLEURA.

By *THOMAS H. BABINGTON, M.B.,*

Surgeon of the County Londonderry Infirmary.

Charles M'Loughlin, aged 57, was admitted into County Londonderry Infirmary, Friday, 8th May, complaining of cough, pain in right side, in front of chest, under right clavicle, and along his right arm, with difficulty of breathing, and a feeling of being stuffed up. Pulse 76, same at each wrist; quite regular. Action of heart regular; no murmur; respiration in left lung healthy. Right side very dull on percussion, and the respiration very indistinct, except for a small space at top of lung. Below the right clavicle, towards the sternum, there is a double pulsation following each beat of the heart. This pulsation, somewhat indistinctly heard in front, is very audible and clear behind, along the spine. The first and following examinations led to the conclusion that the patient was suffering from aneurism of the aorta, near the commencement of the vessel.

In this diagnosis I merely verified the opinion of my friend, Dr. Forsyth, Medical Officer of Calmore Dispensary, who sent the patient to the infirmary with a note, saying, "I send you a case of aneurism of the aorta."

Some relief was afforded to the cough and diffi-

culty of breathing. On Tuesday, the 12th May, about an hour after he had eaten his dinner, he turned over in bed on his right side, and expired without a groan or a struggle.

Post-mortem examination.—Left lung healthy; rather larger than natural. Pericardium large; its walls much thickened; contained about four ounces of serum; no adhesions. Right pleura contained two quarts of serum, and above five pounds weight of coagulated and fluid blood. Right lung small and compressed; lower lobes almost solidified, and filled with grey tubercles. The whole structure of the lung was dense and solidified, except at the top of the upper lobe.

The heart, lungs, aorta, and trachea were removed. An aneurism was found about the size of a turkey's egg, springing from the very origin of the aorta posteriorly. The sac was adherent to the root of the lung, for about an inch and a half, and close to this an opening was found, about half the size of a garden pea, through which the fatal hæmorrhage had taken place. There was no blood in the heart or the aneurismal sac. The sac was divided into two chambers by a dense fibrous septum.

The valves of the heart, both mitral and aortic, were much thickened. The aorta was greatly thickened and diseased, of a highly vascular appearance, with soft deposits all over its lining membrane, and had evidently been extensively inflamed.

May 1844, 1857.

ON CHYLOUS OR MILKY DIARRHŒA.

By Dr. DILLON KELLY, M.R.C.S.L.

Mullingar.

Some notice of this rather rare form of diarrhœa may not be unacceptable to the profession, more especially as although occasionally alluded to by writers and lecturers, I have never yet seen it fully described.

Dr. Benson, in the *Medical Press* for August, 1841, says, "from the appearance of the discharges they were supposed to consist chiefly of chyle, or the fluid of the lacteal vessels, and hence it was sometimes called chylous, or lacteal, or milky. By some they were supposed to contain chalk, or sulphate of lime, and then this variety was called chalky or gypseous. But the colour appears rather to depend on the absence of bile, than on any admixture of chalk, or gypsum, or chyle."

It is called by almost all authors whom I have an opportunity of consulting, chylous or milky diarrhœa; and whether dependant on sudden torpidity of the liver, or obstruction of the ductus communis, or atony or obstruction of the lacteals, it is remarkable how quickly all those symptoms—supposed to depend on great physical derangements—will disappear, and how steadily and

surely the liver will resume its normal action, and the chylo-poietic viscera their tone, without the necessity of having recourse to any very active treatment.

I have lately had an opportunity of observing three cases, in all of which milky stools have been parted with. The first, an adult, the attack decidedly choleraic, and the milky motions both preceding and succeeding to greenish or bilious evacuations.

The second, a child of three years old, who made no complaint of any illness whatever, and played about as usual. She had but one purely milky evacuation; but her motions, although formed, and almost of a natural consistence, had continued for some days of a dead white colour, like well-boiled rice.

In the third case I was myself the patient. For five or six months I had been almost constantly the subject of attacks of gout in my left foot, and which almost totally incapacitated me from taking sufficient walking exercise. Up to the 13th of October, with this exception, I never felt in better health; but on that day I felt rather heavy, and had frightful dreams during that night, with burning heat in my hands and feet, and on the following morning a foul tongue, bad taste in my mouth, and slight thirst. From that day I began to look ill occasionally, suffering from a foul, rough, velvety-looking tongue, and considerable thirst; but I felt neither languor, debility, or loss of appetite, until the morning of the 21st, when, after a fatiguing journey on the previous day, an uneasy sensation in the bowels, as if I had taken aperient medicine, was followed by a full fluid motion, the colour of which I had no idea of, but which was perfectly free from fetor. I suffered now from an intensely hot, dry, and burning sensation in the palms of my hands, and in my feet. After breakfast I had another fluid motion, but not so copious as the first one. I was now travelling by rail, and my left foot became hot and painful. My stomach became sick, and I ejected without much effort, and with instantaneous relief, a very large quantity, indeed, of thick, whitish, creamy-looking fluid. The vomiting returned a second and a third time, and was succeeded by a sensation of fulness in the stomach, and most offensive eructations. When I reached home, I took a hippo emetic, and when it had affected me twice, a spoonful of pure brandy immediately checked the vomiting, which did not afterwards return. At nine, p.m., I felt so well I supposed it would be all right next day, as with the exception of the dry, burning state of my hands, and hot skin, I had nothing to complain of. During the night I felt very hot, had much thirst, and slept but little, but my bowels were perfectly quiet until between two or three o'clock, a.m., when they again became troublesome, and I then, for the first time, discovered that the dejections were unmistakably milky in appearance.

By the advice of Dr. Duigan, I took half an ounce of tincture of rhubarb, and as I felt rather thirsty, drank cold water rather freely, and the colder it was the more grateful I felt it, and the better it seemed to agree with me.

Up to 10, p.m., I had five or six motions, still milky, yet not very copious, the last ones slightly tinged with the rhubarb.

22nd.—Dr. Duigan again saw me, and finding my tongue still rough and velvety, pulse 95, and the diarrhoea not removed, he advised some counter irritation over the abdomen, and I took five drops of laudanum, on a little sugar, which checked the diarrhoea till late in the evening, when I had two more fluid but scanty motions.

23rd.—Between three and four in the morning I felt, for the first time, a slight degree of tormina, which was succeeded by a motion semifluid, and becoming more consistent, but still perfectly white; between that and ten I had three more, each somewhat more consistent than the preceding, and having exactly the appearance of thick, white, flour paste, with some curdy-like flocculent scybalæ interspersed. After some further counter irritation, the diarrhoea totally ceased.

During the following day my urine deposited a copious pinkish-like sediment, evidently lithates; the burning heat disappeared from my hands, but I was annoyed with a hot creeping sensation in my skin, and slight pain, or rather numbness, in my back and loins, with considerable languor, and I also suffered from tormina occasionally.

On the 25th, bile re-appeared in the motions, but I was much annoyed with a most unpleasant taste on my mouth, malaise, and restlessness, for some time.

Subsequently my bowels were irregular for about six weeks, when an attack of local inflammation in the region of the cæcum, accompanied with tormina and a considerable amount of soreness on exertion, or coughing, or pressure, set in, which confined me to my room for four or five days, and which required leeching for its removal, after which my convalescence, though slow, was progressive and complete.

appetite and listlessness; the bowels were obstinately constipated, and they being relieved by active purgatives, the little patient seemed to improve, but in a very short period convulsions came on, which, without ceasing, proved fatal in seven hours. On making a *post mortem* examination, Mr. B. found extreme congestion of the meninges, especially of the pia mater. At some points this amounted to sanguineous effusion. There was not any great quantity of serous effusion either in the sub-arachnoid spaces, ventricles, or base of brain, but at several points there were deposited in the sub-serous tissue numerous small tubercular masses, about the size of millet seeds. These were especially evident between the central hemispheres, along their inferior margins in the median fissure, above the raphe of the corpus callosum.

Dr. MOORE presented a *fatty tumor* nearly two pounds weight, which he had dissected from the lumbar region. The patient attributed its origin to an injury which he had received six years ago. During the operation there was not over half an ounce of blood lost; sutures were applied, and the wound healed by the first intention. The patient was moving about in six days.

Dr. MOORE exhibited a globular pessary $2\frac{1}{2}$ inches in diameter, which had been introduced into the vagina six years ago; it had never been removed since, and latterly caused such an amount of irritation as to demand its extrication, which was effected with some difficulty by the lithotomy forceps.

The SECRETARY presented a

"Mole,"

sent for exhibition by Dr. H. PURDON. It was about $4\frac{1}{2}$ inches in its perpendicular diameter, and $2\frac{1}{2}$ in its transverse. In form it represented a model of the uterine cavity. The structure was loose, reticulated, and of a fibrinous character. On making a section, a cavity was laid open, containing a small amount of serous fluid, and lined by a thin serous-like membrane, but no appearance of any blighted foetus could be discovered; seven months had elapsed from the cessation of menstruation until its expulsion. The uterus continued enlarging for four months and a-half, it then began to decrease in size. The os was dilated, and the cervix continued enlarged. During the time it was carried, no sickness was experienced, and the patient became very fat. Once or twice there was a slight discharge of blood from the uterus, and at the termination it was shed with a good deal of pain and hæmorrhage. There was a well-marked areola. Dr. Purdon had known, during the time a mole was being carried, the patient to suffer from constant tinnitus aurium and vertigo.

Prof. FERGUSON inquired as to the opinion of the members in regard to the pathology of such masses. He considered that when an ovum was con-

Proceedings of Societies.

BELFAST CLINICAL AND PATHOLOGICAL SOCIETY.

Twentieth Meeting, March 14th.

The President, Dr. M'GEE, in the Chair.

Mr. BROWNE detailed the history of a case of

Tubercular Meningitis,

and presented the results of the *post mortem* examination. The subject, a child of three and a-half years old, had been labouring under some slight malaise for some days, complaining only of loss of

vayed into the uterine cavity and died, that it acted as a foreign body, causing irritation and inflammation. He therefore regarded the present morbid specimen as a product of inflammation.

Dr. ROSS referred to Dr. Montgomery's classification, into true and false moles, and stated that he considered impregnation as necessary to the production of such masses.

Dr. BRYCE referred to a mole which he had examined some years ago, and in the cavity of which he discovered a blighted fetus, weighing only six grains. Under the microscope, however, he was able to distinguish different members of the body.

Twenty-first Meeting.

The President, Dr. McGEE, in the Chair.

Dr. ROSS detailed

Two cases of Pyæmia.

The first was that of a boy, aged 13 years, "who," said Dr. ROSS, "had been in good health until a few days before I saw him. His friends attributed his illness to a beating by an elder boy. He had slept in a room, the air of which was polluted by a number of pet birds, amongst which, even by day, he spent much of his time. I visited him on the second or third day after a rigor, and the sixth after the beating. I found great sinking of the vital powers; his pulse very quick, sordes on his teeth, and a dry, brown tongue; and great pain and tenderness behind the left trochanter, where a large abscess formed in a few days. Its situation was so deep, that I introduced a bistoury nearly its entire length before I reached the matter. Considerable relief followed its evacuation; but in a day or two the left testicle swelled to about four times its natural size, became very tender, and the scrotum red and inflamed, and *pari passu*, a large, inflamed, and tender tumor appeared over the acromial end of the right clavicle. In a few days a similar kind of tumor was observed over the left ilium. These three, viz., the one of the testicle, that on the clavicle, and that on the ilium, disappeared without ending in abscess, though the formation of matter appeared imminent. I treated the patient with quinine, stimulants, and good diet. Diarrhoea was frequent during the most severe period of the attack; the evacuations were very offensive. The emaciation and debility were for some time extreme.

The second case was that of a boy aged eight years, in whom pyæmia supervened on ulcers of the mouth, produced by mercury given for pneumonia; six or eight large abscesses formed in quick succession on the front of the neck, chest, and scapulae. It was quite surprising the amount of purulent matter evacuated from them. The pulse was for several days scarcely perceptible, and the depression very great; but yet, after a tedious illness, the boy recovered. These were apparently the most hopeless cases I ever had under my care; and yet, by sup-

porting the system well, by evacuating matter when formed, and by general attention to health, they did well. The most practical view to take of pyæmia is to consider it a disease of the blood, induced by the addition of pus, or some other septic matter, which deteriorates that vital fluid. In this way we can rationally account for the sudden prostration that attends the absorption of animal poisons. Without entering into the controversy as to whether the abscesses, which are secondary to the contaminations of the blood, are more of than in the part, I may express my opinion that they are more or less both; one or other character predominating in different cases. From the careful examination of the above cases, it appeared to me that the symptomatic deposits are in some cases not pus, but unhealthy fibrine; and that while the effusion is of this character we may hope, by careful constitutional treatment, to cause its absorption. When pus has formed, the sooner, as a general rule, we evacuate it the better. The treatment should be mainly constitutional. The remedies which I consider best are, quinine, stimulants, and nutritious diet; and if there be much sleeplessness or irritability, morphia at bed-time."

The PRESIDENT referred to the case of a young gentleman who received a poisoned wound from handling the feathers of a foreign bird, and shortly afterwards died from pyæmia. He also made several remarks in regard to the relation existing between phlegmonous erysipelas and pyæmia, illustrating his observations by reference to a case of phlegmonoid erysipelas of the leg. One of the medical gentlemen in attendance had very soon after a very severe attack of erysipelas of the head, and a second suffered from a pustular eruption of the hands, and the patient's sister was also similarly affected.

Dr. MOORE exhibited a fibrous tumor, the size of a walnut, which he had removed from the breast of a female, æt. 25 years. It was of four years' growth, and attached to the upper and outer part of the left mamma; of late it had become tender on pressure, and accompanied by severe neuralgic pains, extending along the inner side of the arm to the point of the shoulder and scapula. He also presented a tumor of a cancerous nature, removed from the right breast of a female, æt. 44 years, about the size of a nutmeg. There was no swelling of the glands in the axilla, or above the clavicle.

RED LINE OF THE GUMS IN PHTHISIS.—Drs. Saunders and Draper, with the view of testing the value of the sign of phthisis indicated by Thomson, have examined the gums in 451 cases of various forms of disease occurring in the Bellevue Hospital. They conclude, 1. The red line, though it occurs frequently in phthisis and chronic blood diseases, is by no means characteristic of them. 2. In pregnant and recently-delivered women, it occurs more frequently and is better marked than in any cases examined. 3. That age and sex exercise no influence on its existence.—*New York Journal*.

UNIVERSITY OF ST. ANDREWS.

MEDICAL EXAMINATION PAPERS, MAY, 1857.

FIRST EXAMINATION.

FIRST PART.

Translation of a Latin paragraph into English.

Give the derivation and primary meaning of the following words:—Oxygen, chlorine, iodine, aphonia, stethoscope, hæmoptysis, rhinoplastic, and cathartic.

SECOND PART.

Chemistry.

1. Enumerate the compounds which oxygen forms with nitrogen, stating what they are, and writing their formulae.

2. Give the processes for the formation of sulphuric, muriatic, and nitric acids.

3. State the principal tests for arsenious acid in solution; also for the salts of lead in solution. What are the antidotes for the latter, and for corrosive sublimate?

Materia Medica.

4. What are the pharmacopœial preparations of mercury that are used internally? State their uses, and average doses.

5. What are the principal uses and proper (average) doses of the following preparations?—

1. Gallic acid. 2. Tincture of aconite. 3. Solution of arsenite of potash. 4. Extract of belladonna. 5. Tincture of cantharides. 6. Acetic extract of meadow saffron.

6. Write a Latin prescription (without using abbreviations or symbols) for an aperient draught; and give directions that it should be taken the first thing in the morning, and that the dose should be repeated every third day.

SECOND EXAMINATION.

Anatomy and Physiology.

1. Sketch briefly the distinctive characteristics of man.

2. What is the average quantity of food required for the maintenance of the human body in health? Give diet-scales respectively suited for men in regular active exercise and for the inmates of workhouses, with reasons for your selection. What are the principal arguments for and against the moderate use of alcoholic drinks?

3. Give a sketch of the ordinary and minute anatomy of the salivary glands, and state what you know regarding the chemistry and functions of their secretions.

4. Describe the anatomy of the shoulder-joint, and give the attachments of the muscles by which it is strengthened.

5. What are the effects of continuously respiring a vitiated atmosphere? What is the average mortality in Great Britain, or any part of it? How far is it supposed it might be decreased by sanitary improvement?

THIRD EXAMINATION.

N.B.—In answering the practical questions, the Examiners require every candidate to specify the mode of treatment he is in the habit of adopting, and the doses of the medicines which he prescribes.

Pathology and Practice of Physic.

1. Describe the principal modes in which the blood is altered in disease.

2. Explain how diseased conditions of the heart, liver, and kidneys, may produce dropsy. How would you treat the dropsy arising from these different causes?

3. Describe the symptoms and treatment of delirium tremens. How may it be distinguished from acute inflammation of the brain?

4. How would you distinguish between carcinoma and chronic ulceration of the stomach? In what different modes may the latter prove fatal? Give a sketch of the treatment you would adopt in these diseases.

5. Describe an ordinary case of continued fever, terminating in recovery. State how you would treat such a case. What are the arguments for and against special fever wards in hospitals?

FOURTH EXAMINATION.

Surgery.

1. Describe the mode of performing the operation of lithotomy, and give its advantages and disadvantages as compared with lithotripsy.

2. What are the symptoms and the diagnostic marks of the different kinds of iritis, and what the treatment proper for each?

3. State the causes, symptoms, progress, and treatment of cancrum oris.

Midwifery.

4. Describe the structure of the placenta, and its relation to the uterus and its vessels.

5. Give the symptoms and treatment of puerperal peritonitis, as distinguished from puerperal fever.

6. What is trismus nascentium? State its causes, its symptoms, and the morbid appearances after death.

VACANT CHAIRS.—The Chair of Materia Medica is now vacant in two of the Queen's Colleges in Ireland: in Belfast by the death of Professor Stewart, and in Cork by the election of Dr. Alexander Fleming, the late Professor, to be Physician to the Queen's Hospital, and Joint Professor of Materia Medica in Queen's College, Birmingham, in the room of the late Dr. George Fife, who had resigned these appointments shortly before his death.

DEATHS.

At Mountmellick, on the 12th instant, after a long illness, Dr. DOWLING, aged 50.

At his residence, Belfast, Dr. HORATIO STEWART, Professor of Materia Medica in Queen's College, in the 37th year of his age. Dr. STEWART graduated in Glasgow in 1839, and took a diploma in Surgery from the Royal College of Dublin in 1840. His death, in the prime of manhood, and in the midst of his usefulness, will be severely felt in Belfast.

COMMUNICATIONS have been received from Dr. Shinkwin; Dr. Thorp; Mr. Barrington; Mr. Edmonds; Dr. Babington; Dr. Thompson (Omagh); Dr. O'Donovan (Belturbet); Dr. O'Neill; Dr. D. Kelly; H. M. Johnston, Esq.

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OBSERVATIONS UPON
DISPLACEMENT OF THE SCAPULA,
THE RESULT OF PARALYSIS OF THE SERRATUS MAGNUS
MUSCLE.

By J. K. BARTON, M.B., L.R.C.S.I.

Senior Demonstrator of Anatomy, Trinity College
Medical School.

Among the various causes which produce the displacement of parts from their normal position, should be enumerated a partial paralysis of the muscles attached to them. As examples of displacement produced in this way, I may mention paralysis of the muscles of one side of the face, causing the mouth to be drawn to the opposite side, the portio dura of the seventh nerve being paralysed upon the right side, the mouth is drawn to the left, by the muscles of that side, now no longer opposed by the paralysed set: also the flexed wrist, and fingers forcibly bent into the palm by the unopposed flexors, in cases where the extensors only of the hand have been paralysed. The bones are in general secure from displacement from this cause, beyond what the joints admit of, on account of the ligaments which bind their articulating extremities together. The scapula, however, being united to the trunk solely by muscles, is more open to this paralytic displacement than any other bone, and consequently we find a dislocation of one or both scapulae has not unfrequently been observed, and accounted for upon the supposition of the paralysis of the serratus magnus, and consequent contraction of the trapezius and levator anguli scapulae muscles.

The displacement, in its earliest stage, merely consists in a projection of the inferior angle of the scapula, most marked when the arm is raised above the head. This, should the disease progress, gets more prominent, while the posterior edge of the bone begins also to project from the ribs, so that the fingers can be readily thrust beneath it. The whole scapula now becomes drawn from its natural position in a direction upwards and in-

wards, so that the posterior edge approaches the spine, while the posterior superior angle is raised to the back of the neck; the bone finally becomes rotated upon itself, the glenoid cavity being drawn down by the weight of the arm, while the posterior superior angle is raised high in the neck, and the inferior angle projects from two to three inches from the ribs.



This displacement was at first accounted for upon the supposition that the inferior angle of the scapula had escaped from beneath the latissimus dorsi muscle, as it passes across it to be inserted into the humerus. The anatomist, however, cannot agree to this, for he knows that it is the serratus magnus, and not the latissimus dorsi, which holds the scapula to the trunk; the

last-named muscle passing too loosely across the bone to confine it in any way. And besides, although the earliest stage of the deformity, when the inferior angle alone projects, might possibly be accounted for upon this supposition, it is evidently quite insufficient to account for the projection of the posterior edge, and the rotation of the bone upon itself. Again, it has been suggested that curvature of the spine, by forcing out the angles of the ribs, may cause the projection of the scapula. We, however, see numerous cases of curvature of the spine in which no projection of the scapula has taken place; and again, in several of the cases of projecting scapula, there has been no curvature; so that we cannot place them in the relation of cause and effect, in the majority of cases at least. There remains, then, nothing but paralysis of the serratus magnus muscle to account for this displacement; and the whole deformity is such as would be produced by this; for the action of this muscle arising from the ribs, and inserted into the posterior edge of the scapula, is, to draw forward this bone, especially its inferior angle, into which the strongest portion of the muscle is inserted, and by so doing raise the shoulder-joint; also, to bind the scapula to the trunk, and thus give a fixed point for the action of the muscles arising from the bone. Also, if the upper extremities be fixed, it can act *from* the scapula upon the thorax, and aid in inspiration. Now in cases in which the displacement I have described exists, we find—1st, the loss of this action. The scapula cannot be drawn forwards; it looks loosely attached to the trunk, and is so movable that the muscles arising from it are greatly weakened, wanting a fixed *point d'appui*; and if the patient be made to fix the upper extremities, and take a forced inspiration, while a hand is placed upon each serratus magnus, the muscle upon the unaffected side will be felt as well as seen to act, while the one on the affected side remains immovable. 2ndly. We find the bone displaced in exactly the opposite direction to that in which the serratus magnus would draw it; that is, the inferior angle projects from the side, while the whole bone is drawn upwards and inwards, evidently arising from the contraction of the trapezius, levator anguli scapulæ, and rhomboid muscles, no longer opposed by the paralysed serratus. From this we may conclude, that the real pathology of this displacement of the scapula is paralysis of the serratus magnus muscle. The causes which produce this are two-fold:—1st, any local injury by which the external respiratory nerve of Bell or posterior thoracic is injured, as that nerve alone supplies the muscle; 2nd, a centric cause—either disease or injury of the spinal cord, by which the serratus magnus is paralyzed, while the trapezius and levator anguli scapulæ muscles remain unparalyzed; which may be, if the disease or injury does not extend higher up than the middle of the cervical region, as the spinal accessory nerve, which supplies the trape-

zius and levator anguli scapulæ, takes its origin from the highest part of the cord, even from the medulla oblongata, while the serratus magnus is supplied through the long respiratory of Bell, from the brachial plexus, which is formed of the lower cervical nerves.

Cases produced by the first of these two, or the local causes, have not unfrequently been observed. Two cases of this kind were brought before the Pathological Society several years ago, —one by Mr. Adams, the other by Dr. Banks; the appearances being shown in Mr. Adams's case by a cast, and in Dr. Banks's by a drawing, a copy of which is given in Fig. 1, as it shows very well the striking points of the displacement. Velpeau, in his *Traité d'Anatomie*,* when describing the long respiratory nerve of Bell, speaks of its injury producing a displacement of the scapula backwards and upwards, with projection of the bone from the ribs, and mentions the case of a young man who had fallen and struck the axilla with the sharp point of a piece of furniture. This was followed by paralysis of the serratus magnus muscle, and projection of the scapula. It had lasted six months when Velpeau saw him, but he recovered by the application of flying blisters along the scapula and side of the thorax.

Not long since, Mr. Brodhurst laid the particulars of a case of this description before the Royal Medical and Chirurgical Society of London.† “The patient was 16 years of age, tall and robust. The right shoulder was two inches higher than the left, and the inferior angle of the right scapula was five inches higher than that of the left side. The postero-superior angle of the scapula projected immediately beneath the skin on the anterior surface of the neck, an inch and a half above the clavicle. Immediately above this point the trapezius formed a thick, prominent cushion. The serratus magnus muscle of the right side could not be distinguished, even during forced inspiration. The motions of the right arm were limited; that is to say, the elbow could be raised only seven inches beyond a right line with the trunk; and violent movements of the arm occasioned pain, in consequence of the projection of the scapula. Paralysis of the serratus magnus muscle had been produced when the patient was two years old, by her being caught by the arm, when falling from the arms of a relative. Weakness of the limb was observed soon after the accident, and in the course of some months the shoulder was observed to be unduly prominent.”

If there was any further evidence necessary to prove that this displacement is caused by paralysis of the serratus magnus, it would be found in the fact, that the treatment most successful in its cure is that for paralysis of this muscle. Dr. Hutton had a case under his care some years ago, which

* *Traité d'Anatomie*, tom. 1, page 303.

† *Medical Times and Gazette*, February 7, 1857.

perfectly recovered under the use of strychnine internally, and blisters and electricity locally. Velpeau's case recovered rapidly, although of six months' standing, when treated by repeated blisterings. Mr. Brodhurst resorted to subcutaneous incision of the tensely-contracted trapezius, for the purpose of restoring the scapula to its place, which was attended with some success. I should, however, be very slow to advise this mode of treatment. In ordinary cases, the power of the serratus magnus can be restored by blistering, electricity along the course of the nerve, and proper internal remedies; and this being done, there is no necessity for any other means of replacing the scapula; for as the muscle regains its contractility, the bone will be restored to its place. In cases, however, where the displacement has lasted a great length of time, the recovery will be much expedited by mechanically keeping the scapula in its proper place; for while the serratus is constantly kept on the stretch, it is in the worst possible condition for recovery; when relaxed, it will much more readily yield to treatment, in the same way that the cure of paralysis of the extensors of the hand is much aided by placing a splint along the forearm, which, by supporting the hand, relaxes the extensors. I would suggest that, in cases demanding interference of this kind, a padded leather coralet might be made to fit the scapula, and be so strapped to the trunk as to maintain the bone in its natural position, while the paralysis of the serratus was combated by the means already mentioned. The second class of cases—viz., that in which paralysis of the serratus magnus arises from a *centric cause*, and in which, therefore, both muscles are affected and both scapulae displaced—has been but seldom observed: this is not surprising when we remember that the condition necessary for its occurrence is a lesion of the cord affecting the origin of the posterior thoracic nerves, which supply the serrati, but leave unaffected the nerves which supply the trapezius, levator anguli scapulae, and rhomboid muscles. The following case has been recorded by Mr. Banner of Liverpool.* "Mark Barnes, aged 23, of low stature, healthy appearance, was admitted into the Liverpool Northern Hospital 20th of June, 1842, with a projection of both scapulae, and an inability to perform certain actions with the arms. He has, all his life, enjoyed good health, with the exception of the inconvenience arising from the paralysis, which was not preceded by, nor is it accompanied with, any pain in the head or spine, nor any diseased sensations in the skin or extremities indicative of cerebral or central nervous lesion, by which the paralysis might be explained. He is a joiner by trade. Eleven years ago he consulted me for the first time, experiencing at that period a slight difficulty in raising the right arm above his

head. This he felt more particularly when striking any object placed higher than his head. This loss of power gradually increased, and at the expiration of 18 months or two years the base of the scapula on the right side was noticed to stand out from the back; and at the end of three or four years it assumed its present appearance. At the same time the right lower extremity began to fail him, his gait becoming rather unsteady; and when in the bent position, he experienced a little difficulty in raising himself. About four years ago, being seven from the commencement of the attack, the arm of the left side became similarly affected, the scapula being displaced; and the lower extremity began to fail him, as on the right side, although he retained more power in the left arm than in the right. The circumstance which more particularly strikes the attention in the present case is, the appearance of the scapulae, more especially when the man attempts to raise and make use of his arms. In the quiescent position, the base of this bone, instead of lying parallel to the spine, is approximated to it, while the lower angle stands out from the ribs a distance of two inches, leaving between the scapulae a deep hollow, the upper angle being drawn high up into the neck, appearing on both sides, to the observer, in front, midway between the shoulder and ear. The clavicle is in its natural position, as is also the acromion process of the scapula to which it is articulated. When the patient attempts to raise the arm, all the appearances are much increased; the base of the scapula approaches nearly to a right angle with the spine, forming, with the base of the scapula of the opposite side, a very obtuse angle; and both stand out about three inches from the ribs. The arm cannot be raised beyond the horizontal position."

Without commenting upon this case, which is ably done by Mr. Banner, in the communication already referred to, I will recount the facts of the following case, which was lately under Dr. Kirkpatrick's care, in the hospital of the North Dublin Union. W. Burgess, 46 years of age, admitted June, 1856, in a low typhoid condition, accompanied by general paralysis. It appeared from subsequent inquiry, that he had been labouring under disease of the vertebrae for many years, which had caused complete paraplegia; but after issues had been opened near the seat of disease he improved very much, so as to possess complete control over his bladder, and to walk with the aid of crutches. Some time before his admittance to the workhouse, he had been exposed to cold and wet, and suffered from hunger and every sort of privation, when his former symptoms returned, accompanied by a low typhoid form of fever. Under Dr. Kirkpatrick's care he recovered from this state, to such an extent as to be able to get about with the aid of crutches. His digestion was good, and he soon became fat; he complained very much, however, of being unable to use his arms; and it

* See Transactions of the Provincial Medical and Surgical Association, vol. x., page 344, where further particulars and a plate of the deformity are given.

was upon proceeding to examine his spine, in connexion with this remaining want of power, that the remarkable displacement of both scapulæ, shown in the accompanying figure (which was



drawn from a cast* taken shortly after this) was first noticed. He was unable to raise his arms beyond the horizontal position; when he attempted to do more than this, the projection of the scapulæ was increased, and in his ineffectual efforts, they moved up and down in an extraordinary manner, looking as if they were loose beneath the skin. When one of the scapulæ was firmly held in its proper position, he could then move the arm much better. Firm pressure upon the spinous processes of the vertebræ, between the scapulæ, caused some pain. Cicatrices of issues existed upon either side of the lumbar vertebræ, where there was a curvature convex forwards; so that here, no doubt, was the original seat of the disease. The serratus muscle upon each side was manifestly atrophied; also the latissimus dorsi, the deltoid, supra and infra-spinatus, and teres muscles, were soft, and smaller than natural, but not much so. The muscles of the arm and forearm were also atrophied to some extent. The man's digestion was good, and his strength increasing, so he was ordered as good rations as the dietary afforded. No special treatment was adopted for the displacement of the scapulæ; but upon a cast being taken, he in a few days left the house, alarmed, I suppose, by the interest his case excited.

The sequence of pathological events, and explanation of phenomena observed in this case, seems to have been as follows:—In the first instance, some of the lumbar vertebræ were attacked with caries, the irritation connected with which being propagated to the cord, produced paraplegia. By means of rest and counter-irritation a stop was put to the caries, which resulted, as is sometimes the case in this part of the spine, in a curvature convex forwards. Subsequently, under the influence of cold, wet, fatigue, and insufficient food, disease was set up in the already enfeebled cord, which caused almost complete paralysis for the

time. The disease in the cord then yielding to treatment, the patient gradually regained the use, first of his lower limbs, then of his upper—but of these last very imperfectly; for the trapezius and levator anguli scapulæ muscles receiving their nervous supply from the very highest part of the cord, were never affected, and consequently when all the other muscles attached to the scapulæ were paralyzed, they drew these bones out of their natural position upwards and inwards. Now, the nervous centre having recovered itself, all the muscles should have gradually regained their power; but the muscles inserted into the scapula were, on account of the displacement of that bone, very unfavourably placed for their recovery, particularly the serratus magnus muscle, which must be constantly kept stretched to its utmost limit by this displacement; hence this muscle would naturally be the last to regain its function, if it ever did regain it; and it would be just at this time, when the centric disease had passed away, but the serratus magnus remained paralyzed, that the displacement of the scapula would be the most remarkable.

From the foregoing observations we may, I think, safely draw the following conclusions.

1st—That the scapula is subject to a displacement, commencing in a projection of its inferior angle, the bone being subsequently moved in a direction upwards and inwards.

2nd—That this displacement is the result of paralysis of the serratus magnus muscle, and consequent retraction of the muscles which oppose it.

3rd—That this paralysis may arise—*first*, from disease or injury of the external respiratory nerve of Bell; and *second*, from disease or injury of the spinal cord.

4th—That cases produced by the first of these causes may be cured by blistering and electricity locally, with suitable general treatment.

5th—That the displacement in the second set of cases may be accounted for by the fact of the trapezius and levator anguli scapulæ muscles being supplied by the spinal accessory nerve, while the serratus magnus is supplied from the brachial plexus.

6th—That in cases produced by a centric cause, the first and most necessary thing is to restore the nervous centre. This being accomplished, the recovery may be facilitated by mechanically keeping the scapula in its normal position, while the paralysis of the serratus magnus is treated locally.

SEA SAWDUST.—Mr. M'Donald, Assistant-Surgeon to the Surveying Ship now in the Pacific, has sent a paper to the Royal Society, on the so-called sea-sawdust. He finds it to consist of small adherent bundles of minute filaments, with globules of air between, and states that it should be classed with the *Oscillatoria*.

CHLOROFORM IN SEA-SICKNESS.—Dr. Landerer, of Athens, states that from ten to twelve drops of chloroform in a little water, is an unfailing remedy in seasickness. One dose has been known to give immediate relief.

* There is a similar cast in the museum of the Richmond Hospital, the history of which I have not been able to learn.

WHITWORTH HOSPITAL.

CLINICAL REPORTS OF MEDICAL CASES.

By J. T. BANKS, M.D.,

King's Professor of Physic; one of the Physicians to the Hospital.

Tubercular Peritonitis—Artificial Anus.

John Magee, aged four years, was admitted into the Whitworth Hospital on the 29th of December, 1856. The child's mother said that he had been a strong, healthy, "well-thriven" child until last June, when he was attacked with scarlatina, which from her account appears to have been of a rather severe character. From this period the child was delicate. He had a "slight cough;" he lost flesh; his appetite was indifferent, &c. He never again regained the state of health which he had enjoyed previous to the scarlatina.

A month before he came into hospital his mother observed that the scrotum was considerably enlarged. This circumstance at once arrested her attention; and, believing the swelling to be a rupture, she applied at the Richmond Hospital for advice, and was then told to bring the child to the Whitworth Hospital, which is adjoining. This advice she did not follow for a considerable time, until the abdomen became much increased in size. On admission the child presented a remarkably anæmic appearance. The face was slightly puffy, and altogether there was that about the child which at once suggests the suspicion of the existence of renal disease. The scrotum was oedematous, and the abdomen much enlarged, measuring 30 inches in circumference. Fluctuation was very evident. There was no anasarca of the lower extremities. A physical examination of the respiratory organs did not reveal anything abnormal. The urine was below the average in quantity, and was highly albuminous. For the first six weeks after the child's admission into hospital he improved in health. The abdominal effusion became much diminished, the urine more abundant, the appetite better, and the anæmic appearance was by no means so marked. A general amelioration of all the symptoms had obviously taken place. The improvement, however, was delusive, and of short duration. The child gradually wasted away; the lower extremities became oedematous, the pulse rose in frequency, there was constant thirst, and in the morning the body was bathed in sweat; the bowels were irregular, generally disposed to be rather lax. The most accurate examination of the abdomen now failed to elicit evidence of fluctuation. The abdomen was altered in form, it was irregular, and the umbilical region was dull on percussion. The sensation communicated to the hand was as if all the viscera contained in the peritoneal cavity were agglutinated together, and formed one mass. There was not, at this time, or at any antecedent or subsequent period,

the slightest tenderness on pressure, nor did the child complain of pain, or even of uneasiness, in the abdomen. The appetite throughout the course of the disease was surprisingly good. The stomach never rejected food, and it was taken in sufficient quantity. The bowels continued to be irregular, but the tendency in general was to diarrhoea. In the state described the child continued until the 15th of March, on which day an oozing of purulent matter was observed from the umbilicus. It was very inconsiderable in quantity, and closely resembled in appearance the contents of a strumous abscess.

On the 18th of March, three days after the discharge was observed, on gentle pressure being made on the umbilical region, there suddenly issued forth a quantity of dark-coloured matter, the odour of which was most offensive, and in truth was unmistakably fecal. At the time of this event, the child was taking syrup of the iodide of iron and cod-liver oil. The dejections were coloured by the iron, and on comparing them with that which came by the umbilicus, they were found to be *identical*.

From the establishment of this *artificial anus*, up to the close of life, the contents of the bowels flowed from the umbilical opening more abundantly than they were passed from the rectum. They were at times formed, but in general were fluid; the latter being the state in which they were also passed per anum.

The downward progress of the case became slightly accelerated from the date of the formation of the unnatural passage; still the child took food and wine, and seemed to enjoy them. For a few days before the fatal termination, dysentery existed; the evacuations were numerous, very scanty, and consisted almost exclusively of bloody mucus, and under the effects of this new complication, the child succumbed on the 6th of May.

The body was examined twelve hours after death. On dividing the walls of the abdomen, it was found that the peritoneal cavity was completely obliterated. Beneath the umbilicus, and for some extent around, there existed a cavity which contained a considerable quantity of fecal matter, more than was found in the intestinal canal. This chamber was bounded by false membrane, and communicated with the intestine (the ilium) by two small openings with rounded edges. There was also an external aperture at the umbilicus, through which the feces passed freely. The intestines were covered over with tubercular masses, varying in size from that of a pin's head to that of a pea. They were white and opaque, and rather firm in consistence. The whole extent of the peritoneum was studded over with tubercles; but the intestinal portion was more thickly strewn than the parietal. The intestines, in point of fact, formed one mass, to separate the component parts of which was a matter of no small difficulty. There was no serous or purulent effusion between the coils of the intestines. The mucous membrane of the alimentary canal, with the exception of the

openings above mentioned, did not exhibit any abnormal appearance until the rectum was reached, and here were presented pathological changes constituting dysentery of an intensely acute character.

The kidneys were enlarged and hyperæmic, having undergone that change which is looked upon by some pathologists, particularly by Frerichs, as the first stage of Bright's disease. The lungs contained a few tubercles scattered through their tissue. The other viscera were free from disease.

Perforation of the intestinal canal, arising from softening of submucous tubercular deposit, is by no means an unusual event; but the same result consequent upon subserous tubercular deposition undergoing the process of softening, is an event which is rarely met with. In this instance there was a perforation of the intestinal tube and of the abdominal walls. The peritoneum was the seat of extensive tubercular deposition. Inflammation was subsequently set up from the irritation of the tubercles, lymph was poured out, and the intestines were glued together. The general cavity of the peritoneum was obliterated; but at one point, and only at one, viz., behind the umbilicus, was there any effusion. In this situation there must have been some purulent matter, for it oozed out for three days before the fæces appeared. From the period of the establishment of the artificial anus up to the close of life, the discharge from the umbilicus was stercoraceous; and as the openings were in the small intestine, there must have been a reversed peristaltic action. The odour of the discharge at once proclaimed its nature. It may be observed that the duration of life in this child exceeded what might have been expected under such circumstances.

Cancer of the Rectum.—Ileus.

The following case illustrates one of the modes in which carcinomatous disease of the intestinal canal terminates. A woman, aged 40, was admitted into the Whitworth Hospital on the 12th of April, 1857. She was a delicate looking person, very thin, and her skin of a sallow hue; she looked considerably older than her avowed age; and on inquiry it was found that she had ceased to menstruate for some time.

The health of this woman had been, according to her report, tolerably good, with the exception of occasional attacks of obstinate constipation, from which she had suffered, at long intervals, for years. She had been in her ordinary state of health until seven days before her admission, during which time there had been no evacuation from the bowels, and for two days before she was brought to hospital her stomach had rejected everything. She had not been seen by any medical man although she had been so many days ill.

On admission she complained of violent twisting pain in the abdomen, which was much distended. The pain was paroxysmal, and was not increased by pressure; the pulse was not above the natural

standard. The skin was cool. Vomiting incessant. The fluid ejected from the stomach was at first of a greenish colour.

All means resorted to with a view to the relief of the bowels proved unavailing; the symptoms became aggravated. The abdomen increased in size, and after some time it was painful on pressure. The vomiting continued, and the fluid thrown up was dark coloured, and of a stercoraceous odour. The long tube was repeatedly introduced, but it was found impossible to pass it up beyond a certain distance; it appeared to turn upon itself; an obstacle obviously existed, but on examination it was not found to be within reach of the finger. The powers of life gradually failed, but still she lingered until the fifth day from her admission, and the twelfth since the symptoms of ileus supervened upon the original disease. An examination of the body revealed the following morbid appearances:—the peritoneum presented signs of recent inflammation, it was smeared over with lymph, and there were patches and lines of vascularity; no adhesions existed, and there was little effusion of serum. The intestinal tube throughout its whole extent was very much dilated. The rectum was found to be the seat of cancerous disease, which, however, did not occlude the canal completely, inasmuch as a small catheter could be passed through the narrowest portion of the intestine. The disease extended from about four inches and a-half from the anus upwards for two inches; the anus was unaffected, as also the vagina, uterus, and recto-vaginal septum. The malignant stricture appeared to be partly scirrhus and partly encephaloid; the surface was fungoid. The isolation of the malignant growth, the freedom from disease of the neighbouring organs which so often are implicated, and from which the morbid action so frequently extends, are worthy of notice. It may also be remarked that the woman whose case is here reported, at the time she was received into the hospital, then being in the most perfect possession of her faculties, declared that she was in her usual and moderately good health until seven days previously. It cannot for a moment be supposed that such a disease as she laboured under did not give rise to serious disturbance of the general health, and much local pain and distress. To those who are familiar with the lower classes, the declaration of this woman will not appear strange, as it is a subject of daily observation to the hospital or dispensary physician, that poor persons apply for assistance frequently in far advanced stages of disease, stating that they had worked up to the day of application, and that they felt little or no inconvenience until within the last few days. Disease often assumes a most distressing form before an individual of the labouring class considers it of sufficient importance to seek medical aid.

The consideration of this case leads to the conclusion that even in the absence of any previous complaint upon the part of the patient directing

attention to the seat of cancerous degeneration, this diseased state of the bowel may exist and give rise to ileus which rapidly proves fatal.

Tetanus.

The following case appears to me worthy of record, from the unusual circumstances connected with it, and the absence of any of the causes to which tetanus, either in its symptomatic or idiopathic form, is generally traceable.

A man, aged 40, a shoemaker, was admitted into the Whitworth Hospital on the 5th of January, 1857. He had been formerly intemperate, but for a considerable period he had been perfectly regular in his habits. His health had been good up to nine years since, when he was attacked with pain in the left knee, which after some time was followed by an abscess in the popliteal space, which opened spontaneously, and continued to discharge copiously for twelve months, at the end of which time it healed. The knee-joint had gradually become stiff, and finally immovable. Soon after other abscesses formed in the neighbourhood of the knee-joint, and extended along the leg, and in about two years after the commencement of his illness the ankle-joint became affected as the knee had been, and in the course of some time it also became stiff and useless. From this period the leg was the seat of extensive ulceration, and when he was received into the hospital there existed numerous ulcers about the knee and ankle, and many sinuses along the leg. Delicate as this man's health must have been, he worked and supported his family up to the day before his admission into hospital. On the 4th of January he sat down to dinner, but was surprised at finding that he could not perfectly open his mouth; this was the first circumstance which attracted his attention; he then felt stiffness in his back and shoulders, telling his wife it was as if he had been beaten with a stick. He also complained of severe pain in the epigastrium. A state of perfect locked-jaw was soon established; and the general symptoms of tetanus rapidly increasing in severity, he was brought to the hospital on the following day. The countenance was indicative of extreme distress, the forehead was deeply wrinkled, the angles of the mouth drawn, the body drenched in sweat, and at intervals bent, so that it rested on the head and heels. Violent tetanic spasms occurred about every ten or twelve minutes, in the intervals the muscles of the neck and back were rigidly contracted. The paroxysms increased in severity, the breathing growing more and more laboured; the pulse rising in frequency, and becoming very feeble. After a series of fearful struggles, and respiratory anguish of the most distressing character, he died, apparently asphyxiated, the disease having run its fatal course in forty-eight hours.

It was found impossible to procure permission to examine the body in this case.

A most accurate inquiry respecting the previous history of the man whose case has been detailed, was made, and questions put to his wife as to every circumstance which might elicit information touching the etiology of the disease, but nothing satisfactory could be obtained. She stated that for the last two months she noticed her husband "wearing away and quite heartless," meaning by "heartless," depressed in spirits. Of the long list of causes said by systematic writers to be capable of producing tetanus, not one existed. There had not been exposure to cold, a cause to which so many cases of tetanus are ascribed, nor had there been any sudden arrest of the flux from the ulcers which had existed, with the exception of short intervals, for many years. The ulcers had been more painful than usual for a short time previous to the access of the tetanus, and some applications of a soothing nature, as linseed meal poultices, &c., had been employed; and of late cabbage leaves—a favourite popular remedy to promote suppuration—had been applied. There was nothing peculiar in the appearance of the ulceration. In some situations it was found that a sinus existed connecting two patches of ulceration. The knee and the ankle joints were enlarged and perfectly motionless. The limb presented the usual appearances observed when strumous disease has long existed and made extensive ravages.

The question of interest in this case is connected with the etiology of the disease, and the arriving at anything like a satisfactory explanation on this point, appears to be a matter of no small difficulty. True it is, that cases of tetanus have been recorded, which could not be traced to any recognized cause; such cases, Wunderlich suggests, may have been, in point of fact, examples of spinal meningitis; but this supposition could not avail in the present instance.

A case similar to the one under notice has not been observed by me, nor have I seen any such noticed in the numerous works upon the subject of tetanus.

In the absence of all the ordinary causes of tetanus in the case before us, we must look to the state of the limb for a probable solution of the difficulty. It may be that the tetanic disease was produced by the irritation propagated from the limb to the nervous centres, and thence to the muscular system; or, in other words, we may seek an explanation of the phenomena by having recourse to the theory of reflex function. This, at least, appears to be the most reasonable hypothesis.

The progress of this case was rapid, and the symptoms hourly increased in severity, resembling those of the most severe form of traumatic tetanus. The prognosis, from the first moment the man was seen, was to the last degree unfavourable.

It only remains to allude briefly to the treatment employed. All that could be expected was to alleviate the fearful sufferings under which the patient laboured. Fortunately this was attainable,

in a great measure, by the frequent inhalation of chloroform. Under its influence there was a marked amelioration; and frequently a small quantity of fluid was swallowed, after the chloroform had been inhaled for a few minutes, deglutition being previously impossible, and the jaw firmly locked.

In the 13th volume of the *Dublin Quarterly Journal* I published a case of tetanus, successfully treated by chloroform inhalation, and I shall repeat the opinion I then gave on the subject of the treatment of this formidable malady by chloroform inhalation. I then urged the propriety of giving chloroform a full and extensive trial, and of having recourse to it even in cases in which, from the first, there is a tendency to a fatal termination, believing that we have still an agent at our disposal which has the power of allaying pain and spasm for a season, and rendering the last moments of life comparatively free from suffering; for even in those cases in which we cannot expect that our efforts are likely to be crowned with success, we shall, in any event, enjoy the high gratification of making "smooth the path which leads to dissolution."

FROTTEMENT IN INFLAMMATION OF THE SHEATHS OF TENDONS.

By HENRY THOMPSON, M.D.,

Surgeon to the Tyrone Infirmary.

Three cases have occurred to me lately, in which the patients complained of pain in different parts of the forearm, the cause of which, without the physical signs above mentioned, would have been obscure. In each instance the patient had been engaged in some work to which he had been previously unaccustomed. One gentleman was so anxious to get his potatoes set, that he took the spade in his own hand, and laboured with it the greater part of a day. Next morning his arm was useless, from a severe pain along the radial side of the forearm, increased to torture whenever he moved his thumb, on which occasions he was sensible of a creaking sound in his arm, so remarkable, that it was mistaken for the crepitus of a fractured bone by the gentleman to whom he first applied; and when I saw the limb it was done up in splints and bandages *secundem artem*. I placed a stethoscope on the part, and made the patient apply his ear to it, when he at once compared the noise to the creaking of a new shoe.

A young lady, very fond of the piano and harp, became suddenly, and to herself unaccountably, incapacitated from practising, from a pain along the front of the forearm, in the course of the flexor tendons, greatly increased by stretching the fingers. By catechising her pretty closely, I found she had been busily engaged in preparing a house for a newly-married relative, and had been employing herself in sewing carpets, which

were new and heavy, and required a great deal of force to pull the breadths into their places. This was quite enough. On applying my fingers and moving hers, I felt the grating, and at once diagnosed the case.

The other was in an hospital patient, and was very similar to that first described. There was some slight fulness in the affected parts, as well as some tenderness on pressure; but neither was very remarkable, the great complaint being the pain on motion. The cure was somewhat tedious in all, and seemed to be favoured by rest, a few leeches, and cold washes at first, and subsequently by tincture of iodine and liniments; but ultimately both pain and frottement disappeared.

May 21, 1857.

ON THE USE OF TARTAR EMETIC AND OPIUM IN CONVULSIONS.

By Dr. O'DONOVAN, Belturbet.

February 18.—At 10 o'clock, p.m., I was called to see a gentleman, æt. 29, of sanguineous temperament, and very intemperate habits, who had been indulging rather freely, and when going up stairs to bed stumbled and fell backwards, alighting on the occiput. He received a contused scalp wound, about an inch and a half in length but not deep. He was able, with assistance, to walk up stairs and undress, having lost about an ounce and a half of blood from the wound.

19th.—He slept heavily all night; towards morning he had some bilious vomiting, but says he feels quite well; and he has no pain, except from the cut. His pulse is 100, soft; his tongue a little coated. He took a cup of tea, and consented to remain in bed and have some aperient medicine. Being obliged to leave town at mid-day, I heard nothing further of him until my return at seven o'clock, p.m., when I found two medical gentlemen in attendance, my patient having been seized with convulsions at one o'clock, p.m., which returned with increased severity every two hours. The fits are of an epileptic character, though he has never previously had an attack of this nature. He screams, froths at the mouth, works his jaws; the extremities become rigid, and his hands clenched. He recovers from a sleep, with his consciousness unimpaired, and he then converses naturally. The pupils act well when they are exposed to the light of a candle.

My medical friends considering the attack dependent on some lesion of the brain, consequent on the fall—*fracture either of the occipital bone or base of the cranium*—had administered a fatal emetic, ordered the scalp to be shaved, a blister to be applied to the nape of the neck, mustard poultices to the extremities, and small doses of calomel to be given every hour, and mercurial inunction to be used.

This treatment was steadily followed until mid-

night, when our patient became rapidly worse, the epileptic seizures now coming on every 25 or 30 minutes. His strength was fast giving way under their severity, and his consciousness in the intervals was less marked. It became evident that if some other mode of treatment was not adopted at once, death would put an end to the scene in a few hours.

Considering the symptoms to have their origin in a *lesion* of "function" only, and that remedial means calculated to tranquillize the nervous system would offer a better hope of success, I suggested the administration of tartar emetic and tincture of opium, as recommended by the late Dr. Graves in "delirium tremens," in the following proportions:

R. Autimonii tartarizati, gr. iv.
Tincturæ opii, ʒi.
Misturæ camphoræ,
Aque fontanæ, āā ʒiv.

Of this mixture, at half-past 12 o'clock, a.m., he got an ounce, which was retained on the stomach; at 15 minutes to one o'clock he had a very alarming fit, which threatened dissolution. At 25 minutes past one o'clock he got an ounce and a half, which was repeated at 20 minutes past two o'clock. At three o'clock he had become more tranquil, and had had no return of the fit since one; his skin was warm and moist, his sleep more tranquil, and when spoken to, said he felt much better; but complains of the blistered surface, which irritated him, and which was now raw and sore, from the constant friction on the pillow. He had vomited a large quantity of yellow and blue bilious matter. At 20 minutes past four o'clock the dose was repeated, and again at half-past five o'clock. From this period he enjoyed uninterrupted repose to nine o'clock, a.m., when he awoke, expressing himself much improved in every respect.

February 19th.—Has had no return of the epileptic fits; is quite collected; has no pain in his head; pulse 102, regular. Was ordered a draught of compound decoction of aloes, a little brandy, and arrowroot.

He had no return of the epileptic seizures, and continued to improve until the 22nd, when I was hurriedly called at seven o'clock, a.m., and found him labouring under delirium tremens. He was exceedingly unmanageable; could with difficulty be induced to remain in bed. He was haunted by spectral illusions. The expression of his countenance was remarkably silly; his pulse tremulous, 102. He was ordered half a grain of muriate of morphine immediately, which did not produce any sleep. At 11 o'clock, a.m., he was much worse; his pulse 120. He was frightened at everything, fancying all manner of horrible things; constantly shouting at the loudest pitch of his voice. He was again ordered the tartar emetic and opium mixture every hour and a half.

Half-past 3, p.m.—Having got three doses, he has thrown off a considerable quantity of bile, but

no sleep has been procured. In consultation with Dr. Halpin, of Cavan, who now, for the first time, saw the case, it was agreed to put a small blister to the epigastrium, and give 12 minims of Batley's solution; and as he was exceedingly violent, and determined to put on his clothes, he was allowed to do so, care being taken to have two men to watch, and prevent him from injuring himself. He eat a few biscuits and drank a little brandy and water during the day. 10, p.m.—No sleep. Ordered 15 minims of the solution. Continued walking incessantly about the room, occasionally stopping to peep through a small hole in the wall; watching most anxiously every transaction which he supposed was going on in his establishment. At midnight there was no change for the better. He looks much exhausted, but is quite as unmanageable. The opiate to be repeated.

23rd.—Had another opiate at five o'clock, a.m., but without any effect of producing sleep. Eat a little bread and milk, the only food he would touch, and this only by leaving it in his way, and taking no notice of his acts. Two o'clock.—Has taken two draughts, but without the desired effect. The blistered surface has, since morning, become exceedingly foul, and a dark patch is appearing where the sinapisms were applied to the calves of his legs. At 9, p.m., we determined to give him 30 minims of chloroform; at half past nine he got 35 more. At 10 o'clock he got 40 minims. At 11 o'clock he appeared drowsy, the vital powers suddenly became alarmingly depressed, and he allowed himself to be laid on the bed, and took half a tumbler of punch at a draught. At this moment his pulse was scarcely perceptible. He continued exceedingly restless, but by great tact was kept in bed; and at one o'clock, a.m., sleep gradually came on, but only in snatches; and he awoke nearly as unmanageable as ever. Towards morning he became more quiet, and was induced to take about an ounce of brandy in water.

24th.—Mid-day.—Continues tranquil, sleeping occasionally, and takes brandy in considerable quantity; is rational when spoken to. His pulse can hardly be felt. The heart's action is normal, but its impulse very feeble. To have brandy *ad libitum*, with jelly. In the evening his pupils became contracted, his breathing very slow—when asleep, from four to six in the minute. There was no moaning or starting.

He lived on to two, p.m., on the 25th, without any perceptible change, his breathing becoming accelerated to 12, but easy and equal. He died without convulsion or struggle.

No *post mortem* examination took place.

The above case presents some points of practical interest deserving of consideration. First, as to the immediate cause of the convulsive seizure. Two practitioners of considerable eminence coincided in opinion, that the train of symptoms before them resulted from "fracture, with pressure on the brain," or probably "wound of the dura mater."

Before assenting to this view we must recollect, that for the first fifteen hours after the accident, there was an entire absence of symptoms of *concussion, compression or irritation of the brain*, and that at no period during the illness did any symptom of "compression" or "concussion" show itself. Were the symptoms, then, dependent on the irritation of a "spicula" from the internal table of the occipital bone? Surely not; for if so, they would not have yielded to any internal treatment. I consider the following summary of facts sufficient to remove the idea of structural lesion:—15 hours interval of ordinary health between the accident and epileptic seizure; freedom from pain in the head; quiet and regular breathing; regular but weak pulse, averaging 110; pupils during the intervals natural, and contracting well when exposed to the light of a candle; and finally, the immediate and entire cessation of the convulsions under the tartar emetic and opium treatment.

The second point of importance for consideration is the cause of the "delirium tremens" setting in, as it did, at a period when convalescence might reasonably be expected, and resisting every possible mode of treatment. I am disposed to consider it as traumatic. It will be recollected that a large blister was applied to the nape of the neck; the surface became exceedingly raw and sore, from the constant moving of his head on the pillow; and though such an extent of blistered surface would not have produced more than inconvenience in a healthy constitution, it is not too much to suppose, that in a constitution so intensely nervous and morbidly debilitated, an irritant impression of so severe a nature, made on the sentient extremities of the nerves, would be reflected on the nervous centres, giving rise to such a train of symptoms as the individual may be predisposed to. This view would also account for the obstinacy of the disease; for owing to his ungovernable state, it was utterly impossible to dress or wash the blistered surfaces. It is well known that blisters, as well as superficial scalds, will produce, in persons of delicate temperament and children, an alarming train of nervous symptoms, chiefly delirium and sleeplessness, which only yield to a sedative treatment.

I will conclude these few practical remarks by expressing my disapproval of the use of chloroform when the vital powers are at a low ebb. In this case I have scarcely a doubt but that another dose would have proved fatal, though the patient was walking about the room at the time. During the course of the past year I attended a gentleman who was fast sinking from venereal cachexia; he suffered from obstinate vomiting for a few days previous to his decease; to relieve it I administered acetate of lead, preparations of opium, prussic acid, and eventually chloroform; but so fearful was the change produced by this last drug, that I was obliged immediately to desist from its further use.

Proceedings of Societies.

BELFAST CLINICAL AND PATHOLOGICAL SOCIETY.

Twenty-second Meeting, March 28th.

The President, Dr. M'GEE, in the Chair.

Meningitis.

Dr. DILL exhibited the brain and stomach removed from the body of an infant eight months old, who had suffered for a considerable time from vomiting, ultimately dying with symptoms of cerebral disease. The lining membrane of the stomach was considerably congested, and its coats thickened, particularly at the pyloric orifice. The pia mater was found intensely inflamed, with distinct purulent deposit at the base of the brain. The lining membrane of the ventricles was found greatly thickened, opaque, and covered with a gelatinous exudation. The substance of the brain was considerably softer than usual. Dr. Dill not having been the patient's medical attendant, was unable to give a detailed history of the case.

The SECRETARY read the following history of a case of

Psoriasis occurring during the early stage of Pregnancy,

communicated by Surgeon Hawthorne, Dr. more:—Mrs. C., æt. 34, states that she emigrated to a southern state of America, when she was pregnant of her first child, and enjoyed good health until it was weaned. After becoming pregnant of her second, she observed a scaly eruption over the abdomen and flexor surface of her extremities, which lasted about four months, and gradually disappeared. After her second confinement, her husband was obliged to come to Ireland, and she was separated from him for two years, during which time her skin remained perfectly clean. She then joined her husband in Ireland, and again became pregnant, when immediately the eruption appeared, and gradually disappeared about the time of quickening. I saw her for the first time in November last. The anterior surface of the body, except the legs, was covered with patches of psoriasis, from the size of a pea to that of a four-penny piece. I gave her arsenic in ordinary doses, but without any benefit. It disappeared at the usual time, as in the previous attacks. This is now her ninth pregnancy, and since the eruption appeared first, it has invariably recurred after fecundation, and persists till about the period of quickening, when the skin gradually assumes its normal appearance. The patient is in other respects perfectly healthy.

Dr. JOHN MOORE detailed the following

Case of Cerebral Disease, occurring in a child.

On Friday, 20th inst., I was requested to visit A.M.,

at eight years, of whom I received the following history. She had been a remarkably sprightly child until a few months ago, when her manners became changed, and she became quiet and taciturn. About a fortnight ago she began to complain of headache, which at the time caused no uneasiness to the family. It increased, however, and she was placed under the care of a homœopathist. Ten days before I saw her, she went up to her mother's bedroom, who was in bed at the time, and said, "Why, mother, I see four people in the bed." From that time the headache continued to increase in severity, and she was confined to bed. She had also been suffering from cough for some time past. When I saw her, she was lying in a semi-conscious state; would remain in a restless sleep for about five minutes, and wake with a moaning cry and contorted features, and cry, "My head, my head." There was urgent thirst present, and the pulse was only 80. A brother had died of hydrocephalus. I ordered counter irritation to the nape of the neck; gave her calomel and rhubarb, followed by castor oil; and, as this failed to move the bowels, a turpentine enema was thrown up, which produced a copious fœtid discharge. The pupils were dilated, but contracted on the application of light. I then ordered Hydr. c. cretâ every two hours, which in twenty-four hours produced violent salivation, with swelling of the tongue, but without any improvement in the symptoms. She was now restless, and mostly in a state of insensibility, and when awake, she was delirious. She soon began to sink, and stimulants were administered, which quieted her a good deal. She finally sank, however, on Tuesday night. There were no convulsions nor strabismus at any time during the progress of the disease.

The *post-mortem* examination was made thirty hours after death. On removing the calvarium, the veins of the brain were found to be congested. The membranes were healthy, and no trace of tubercle could be detected either in them or throughout the substance of the brain. About two drachms of fluid were found in each of the ventricles; and on removing the brain, between five and six ounces of fluid were found at its base. The substance of the brain was not diseased. On opening the chest we found tubercles scattered through the left lung. The pericardium was found universally adherent. The liver was also very large.

Twenty-third Meeting, Saturday, April 4th.

The President, Dr. McGEE, in the Chair.

Dr. SEATON REID exhibited the heart and large blood-vessels of a man, aged 47, who had recently died in the Union Hospital, into which he had been admitted in August, 1855, when he stated that about one year and a half previously he had

suffered from pain and swelling, without redness, in the right ankle; that a few months since he had been under treatment in the General Hospital, for disease of the heart; and that he had lost the power of his right side eleven weeks ago, but had now partially recovered it, and suffered chiefly from pain between the shoulders, and palpitation. In the region of the aortic valves a distinct murmur was heard with both the systole and diastole of the heart, associated with a jerking pulse and lateral motion of the arteries. The diagnosis made on his admission was, that there existed dilated hypertrophy of the heart, with patency of the aortic valves, supposed to be the result of the rheumatic attack presumed to have existed a year and a half ago; and it was thought that the paralysis of the right side was caused by the detachment of some deposit from the valves obstructing some of the cerebral arteries. He remained in hospital for several months, suffering with varying intensity from cough, dyspnoea, pain in his right shoulder and arm, and between the shoulders; but in none of the repeated physical examinations that I made, especially with regard to the last symptom, did I hear anything to lead me to change or add to the diagnosis I had made. He left the hospital in May. He was readmitted in August, 1856, in consequence of a great increase in his sufferings from dyspnoea, oppression in his chest, and palpitation; and he stated that for the first time he had been anasarcaous when at home. This had greatly subsided before he returned, and there was now heard a single systolic murmur, in place of the double murmur, in the region of the aortic valves, and also a systolic murmur at the mitral orifice, which if observed before, was not recorded. In December he complained much of pain along the spine, but repeated examinations detected no murmur along the vertebræ. In the month of January, 1857, a very indistinct diastolic murmur was again heard in the region of the aortic valves, and on two occasions blood was now observed in the sputa; but his chief complaint was still of the oppression in his chest, of the dyspnoea coming on most frequently about two, a.m., of pain between his shoulders, and of startings in his sleep; and the lower limbs now became very dropsical. During the last two months repeated examinations were made, without detecting anything to change the original diagnosis. Forty-eight hours before death, all his symptoms became much aggravated, and he was seized with a severe pain in his right side, which was only partially relieved by a blister; but as his life was now evidently drawing to a close, I did not feel justified in disturbing him by any further stethoscopic examinations. He never complained of any difficulty in swallowing, of any stridor in breathing, nor had his cough any peculiar sound. There was no tumor observed at any part of his chest, nor any local impulse that would suggest the idea of an aneurism. I obtained leave to make a *post-mortem* examination, when it was

found that there was recent pleuro-pneumonia of the lower lobe of the right lung; the left lung healthy, and no tubercle at any part. About the base of the heart there was some easily-removed lymph, indicating recent pericarditis. The heart was enormously hypertrophied and dilated, and the aorta, from its origin, and for several inches in extent, was also greatly dilated, and had a small pouch at the upper portion of the ascending part. The hydrostatic test showed the existence of free regurgitation into the ventricle. On slitting open the aorta, its interior was found quite wrinkled and rough, from a large quantity of calcareous deposit in its coats. The entrance to the pouch was found narrower than the interior, and had projecting across it, for near half an inch in depth, and more than half its circumference, a sharp ridge of calcareous deposit. There were no laminated coagula in its interior. The ventricular surface of the aortic valves was found roughened, but without any vegetations. The substance of both ventricles was enormously thickened, and the cavities dilated, the carnae columnæ enlarged, and the mitral orifice dilated. There was no erosion of either the sternum, the ribs, or the vertebrae. While the *post-mortem* examination showed the correctness of the diagnosis respecting the state of the heart's substance and its orifices, it revealed the existence of aneurismal disease, that, although looked for, I had failed to detect. Finding that my diagnosis was thus incomplete, I naturally turned to the work of our illustrious countryman, Dr. Stokes, and found there an acknowledgment of the extreme difficulty of diagnosis in cases of mixed sacculated aneurism, such as this was; and while he points out the value, in such cases, of the jerking pulse and lateral motion of the arteries, he admits that their value is dependent on our being certain that no such heart disease existed as was present in this case, and relates an instance where an aneurism of this kind had escaped detection, although two of the most eminent practitioners in Dublin had made repeated physical examinations. Dr. Reid remarked, that while there did exist in this case some roughening of the ventricular surface of the aortic valves, yet he considered that the murmurs may have been chiefly owing to the blood passing so suddenly into the dilated aorta; it having been shown that the passage of blood from a narrow to a much wider tube is capable of producing such murmur; and that, disease being so far advanced in both heart and aorta, there were no data to prove in which it had commenced, or the relation in which they stood to each other. It was known to all how frequently pain in the shoulder and arm preceded or followed paralysis; and lately in a case in which severe pain between the shoulders had caused him to make fruitless searches for an aneurism, the *post-mortem* examination only exhibited concentric hypertrophy of the heart.

Twenty-fourth Meeting, Saturday, April 11th.

The President, Dr. M'GEE, in the Chair.

The President read a case of

Softening of the Brain,

which has already appeared in our publication of May 15th.*

Dr. MOORE exhibited a fibrous tumor, which he had removed from the breast of a female, æt. 25 years. It was of four years' growth, about the size of a large walnut, and of late was very sensitive, and attended with pain in the shoulder and inner side of the arm. The patient recovered perfectly. Dr. M. presented another tumor, of a cancerous character, removed from the breast of a female, æt. 46 years; also a morbid growth, about 1 lb. weight, removed from the labium of a prostitute; it contained a watery fluid, and originated in syphilitic ulceration.

The Secretary presented a section of a *fatty tumor*, sent by Dr. RABINGTON, Londonderry, and read the following history of the case:—"You have herewith part of a tumor, removed on Saturday, the 4th instant, from a patient in the County Londonderry Infirmary. It was situated on the outer side of left thigh; was of a flattened oblong shape; its lower end was close to the outer side of the patella, and extended upwards about five inches. It was seven years attaining its present size; and when first noticed, was about the size of a garden pea. Within the last six months it had increased rapidly in size. It had an elastic feel, as if fluid was contained in it. The removal was easily effected by a simple linear incision through the skin, and dividing some bands of condensed cellular membrane, strong enough to have a fibrous appearance. It was contained in a strong capsule of thickened cellular membrane. There was not a single bloodvessel running into the tumor, nor was there an artery divided in the operation. The loss of blood did not amount to two ounces."

Dr. SEATON REID exhibited the following specimens, recently removed from patients who had died in the Union Hospital:—

The first was a case of

Cancerous Disease, seated at the Pyloric Orifice of the Stomach,

in a female aged 45, who had been admitted into the Union Hospital in January last, stating that she had, for some months past, suffered from pain in her right side, and that latterly she had been losing her strength, and was steadily emaciating. She had never vomited, but had been much troubled latterly with acidity of her stomach. On examination a distinct tumor was found in the right hypochondrium, which was quite immovable. Between its upper margin and the ribs a distinct sulcus was felt, the base of which was dull on percussion, and resisted pressure. She had never been

* See page 149.

jaundiced, and the bowels were regular. The immobility of the tumor, the absence of vomiting, and the regularity of the bowels, caused, at first, some difficulty in deciding whether the liver or the pyloric orifice of the stomach was the primary seat of the affection; but as the disease advanced, this doubt passed away, in consequence of the steady and rather rapid enlargement of the tumor, the *sulcus* alluded to remaining the same; so that for some time before death it was considered that the disease was seated in the pyloric end of the stomach. She became gradually weaker, and for the first time, about 24 hours before death, was seized with vomiting. The matters ejected by the stomach and bowels were dark and like tar. She was very desponding and querulous from the time of her admission into the hospital. The *post-mortem* examination found a large amount of cancerous deposit in the region of the pyloric end of the stomach, but so situated that the pyloric orifice was retained permanently open, and free from contraction. Fibrous adhesions existed between this deposit and the margin of the liver and the tissues behind it. Cancerous deposits were also found in the liver, in the mesentery, in the uterus, and a cancerous ulcer in the rectum. No ulceration had taken place in the stomach, and the duodenum was free from disease. The heart was greatly atrophied, as was also the spleen.

In the second case the disease was seated at the *entrance, or cardiac end of the stomach*. The patient was a male, and said his age was 50; but he looked more like a man of 70. He had been intemperate. He was fearfully emaciated, and his voice little louder than a whisper; his abdominal parietes were retracted in upon his spine. He stated on admission that he had lost his appetite about December last; that he had frequent eructations of acid fluid; had vomited everything for the previous three weeks, and the bowels had not acted for 15 days. He was very pale, and remarked that the vomiting generally took place immediately after the food reaching his stomach; but that at times the food appeared to stop at a spot pointed out by him as immediately underneath the ensiform cartilage, and did not get into his stomach, but after struggling for a time with what he called "his pipes," it returned again into his mouth.

There was neither tumor nor dulness on percussion in the region of the pyloric end of the stomach or liver, nor could any hardness be felt in the epigastrium, even when he was asked to cough, so as to tilt forward the cardiac end of the stomach; but the frequent stoppage of food at the point he mentioned, and its immediate rejection from the stomach, even when it had apparently succeeded in passing on, indicated at once that he suffered under obstruction at the lower end of the *œsophagus*, and disease of the cardiac end of the stomach.

His food, up to his admission, had been partly solid and partly fluid, but he thought he got on

better with fluids than solids. He was ordered a pint of sweet milk, and 4 oz. of spirit in it, to be given in tablespoonful doses at regular intervals—a mode of giving nourishment in such cases that has often been very successful. He was also to take a teaspoonful of castor oil every four hours till the bowels acted, which they did after the third dose. He retained a considerable portion of milk during the next 24 hours, and was most cheerful and hopeful as to the result, and approved highly of the whiskey and sweet milk. The evacuations from the bowels were greenish, and continued so for several days. During the three weeks he survived in hospital he was, as is usual in such cases, sometimes better, sometimes worse; but there was, all through, an entire absence of the despondency so characteristic of cancerous disease. For the last ten days of his life the evacuations from the bowels resembled a mixture of black earth and water, but no discoloured fluid was at any time vomited. He complained so much of severe pain in his back, that he was examined repeatedly with the stethoscope for other indications of aneurism.

On alitting open the *œsophagus*, there was found some morbid alteration of the mucous membrane, at various points within two or three inches of the stomach; and there was found also an elongated tubercle, having a strong resemblance to a tongue, even to its possessing a *frenum*, extending from the cardiac orifice up into the *œsophagus*, which at once accounted for the feeling he experienced of the food being stopped at that part, and having to struggle back into his mouth; for it was evident that a perfect valve against the passage on of food would be formed by this substance, if by chance the first morsel that went down got impacted between it and the walls of the *œsophagus*, in this way forcing it down over the entrance to the stomach.

The cardiac orifice was also found thickened, hardened and contracted, from the cancerous deposit; and immediately after entering the stomach, towards its lesser curvature, there was found an excavated sloughy-looking ulcer, with inverted edges, which at once satisfactorily accounted for the immediate rejection of food, even when it had been successful in passing the obstructing valve which has been just described.

The remainder of the stomach was rather thickened, the pyloric orifice narrow, but entirely free from disease. The liver healthy. The spleen not less than natural, and the heart considerably atrophied.

The *œsophagus* was not dilated above the obstruction, as often takes place in such cases; which probably depended on the fact, that the obstruction here was rather owing to this valve-like substance only obstructing occasionally, than to any very great or constant contraction of the cardiac orifice.

The *post-mortem* examination of these cases is very instructive.

In the first patient there were absent two of the most diagnostic symptoms of disease at the outlet of the stomach, namely, vomiting, and the power of moving the tumor across the mesial line; the former, the inspection after death showed to have been owing to the cancerous deposit being in such a position that it retained (contrary to the usual course), the orifice perfectly open, so that there was no obstruction to the passage on of the food; the latter was dependent on the firm adhesions between the liver and stomach, and tissues behind it rendering the tumor incapable of being moved out of its position.

In the second case the *post-mortem* was equally instructive, from its confirming how accurately the patient had described the locality at which the food was occasionally stopped when it was passing into the stomach, and gave rise to "the struggle in his pipes," which followed before it returned into his mouth; and because it also showed the dependence that could be placed in such cases, on the immediate rejection of food, as diagnostic of disease at the cardiac end of the stomach.

The examination of these cases proved also the correctness of the opinion, that when cancer is seated at the pylorus, the duodenum is never involved, but when seated at the cardiac orifice, the œsophagus is always more or less diseased.

Bibliography.

Medical Charities, Ireland.—Fifth Annual Report of the Commissioners of Irish Poor Law.

This Report opens with a tabular synopsis of the amount of relief afforded (under the Act 14 & 15 Vic., cap. 68) at the patients' homes and at the dispensaries, in each province and in the whole of Ireland, for each of the four complete years ending 30th September, during which the Act has been in operation. It appears that, in the last of these years, the total issue of tickets for the four provinces was 741,237, of which 594,673 were for relief at the dispensaries, and 146,564 for visits at the patients' homes. The average poundage on the valuation of Ireland for the maintenance of the dispensaries is slightly lower this year than it was for the last, having been 1.86*d.* in the pound for 1855, and 1.85*d.* for 1856. The obstinate tenacity with which the peasantry of this country persist in adhering to the baneful custom of variolation has long been a cause of considerable anxiety to those interested in the improvement of the social condition of the poorer classes. As yet, however, the efforts of the Government have not been successful in striking at the root of the evil, owing to the great practical difficulties which obstruct the carrying out of the legal provisions against itinerant inoculators, and in many cases the impossibility of securing the conviction of these offenders. In previous Reports the Commissioners

expressed some dissatisfaction in regard to the imperfect manner in which vaccination had been carried out at the dispensaries, under the provisions of the Medical Charities Act; and in the beginning of last spring they addressed a circular to the Committees, requesting them to use their best efforts to promote vaccination, and to suppress, by every means that the existing state of the laws placed at their disposal, the abominable practice of inoculating with the virus of the small-pox. On the whole, the results of this measure have been satisfactory; vaccinations have been more numerous, while the prosecutions of itinerant inoculators have also increased, and in many instances the offenders have been convicted. So far this is gratifying; nevertheless, the Commissioners, in reiterating the opinion put forward in the last Report, as to the imperative necessity of a legislative provision for the more effectual carrying out of gratuitous vaccination, express an anxious desire for the adoption of such measures as have already been recommended, or such others, including the registration of births and deaths, as may appear best calculated to protect the people of this kingdom from the consequences of neglect and prejudice in regard to small-pox.

Scarlatina is shown to have advanced continuously through the summer and autumn; nor does it appear to have been on the decline at the close of the year. Small-pox is reported to have been more prevalent in the spring than in the subsequent months. Cholera, in an epidemic form, was not observed in any part of Ireland during the year.

The Asylum Journal of Mental Science. Edited by J. C. BUCKNILL, M.D.

The late numbers of this excellent periodical contain some unusually interesting and valuable papers on subjects connected with unsoundness of mind in its various phases. Some of these are of a speculative and philosophical cast, while others have a more directly practical tendency; the limited space, however, at our disposal, precludes the possibility of our entering upon an analysis of these papers; we must, therefore, content ourselves with expressing, in general terms, a favourable opinion of the work, with our best wishes for its continued success.

Statistics of Insanity; being a Decennial Report of Bethlehem Hospital, from 1846 to 1855, inclusive. By W. CHARLES HOOD, M.D.

Three classes of patients are received into Bethlehem Hospital, namely, curables, incurables, and criminals. The second class possesses but little interest; regarding the third, the government prohibits the publication of their history; and, therefore, to the first only does the author of this report advert. Thus the work may be con-

sidered as "a statistical history of the patients admitted as curables into Bethlem Hospital, during the ten years ending December, 1855." Each subject of practical importance is noticed in succession, and forms the theme of a distinct chapter, of which there are sixteen; while in the course of the several chapters the reader will find a series of very elaborate tables, the construction of which is the result of a careful review of the reports of the last ten years. The author was thus enabled to improve the tables in use, by amalgamating some, and by adding others, and in this way, by a general view of several tables, to present much valuable matter which could not otherwise be brought to light. This report is in the highest degree creditable to the skill and assiduity of the resident physician.

DR. FELL'S TREATMENT OF CANCER.

In reply to many inquiries as to the nature of the remedies which Dr. Fell has been for some time allowed to make use of in cases of cancer, in the *Middlesex Hospital*, we copy from the *Medical Times and Gazette* the following extract from Dr. Fell's work, with the editor's commentary thereon:—

"My first experiments with the *Sanguinaria Canadensis*, (or as it is commonly termed, 'puccoon,') were made upon ulcerative surfaces; and although requiring months of continued application, yet the removal of the tumor was effected, and the patient cured. It was then combined with various substances, with a view to hasten its action; but none appeared to do so well as the chloride of zinc, for with this compound large ulcerated tumors were removed in a few weeks, with comparatively little, and in many cases no pain; at the same time obtaining, by absorption and by the internal use, all the good effects of the puccoon.

"The next object was, to adapt the treatment to non-ulcerated tumors; and as a preliminary step, the cutis was destroyed by nitric acid, and the paste applied; but it was found that the eschar produced by each application was so thin, that it would require a long time to remove a large tumor.

"Incisions about half an inch apart were then made through the eschar, avoiding the living tissues, and the paste spread upon strips of cotton inserted into them daily. This plan succeeded admirably, and is believed to be entirely original.

"It was also found, that although the action of the puccoon was much hastened by the addition of the zinc, yet it was slow enough to allow its complete absorption, thereby enabling it to exert its peculiar constitutional effects, and at the same time removing the diseased mass in a few weeks.

"The compound generally used is prepared according to the following formula:—

R. *Sanguinaria Canadensis*, ʒss. vel ʒi.

Chlor: Zinci, ʒss. vel. ʒij.

Aquæ, ʒij.

Pulv: Sem: Tritic: Hibern: q. s.

Mix, and form a paste the consistence of treacle.

"Sometimes the *sanguinaria* is used in the form of a decoction, by boiling it down in water from four to two ounces: in this case no water is used in mixing the paste.

"The proportions of the *sanguinaria* and zinc are varied in different cases, according to the effect produced.

"This is spread upon strips of cloth, cotton, or wool, and inserted daily into the incisions. Generally in the course of two to four weeks the disease is destroyed, and the mass falls out in the course of ten or fourteen

days afterwards, leaving a flat healthy sore, which generally heals with great rapidity. This treatment refers chiefly to those cases that are well marked, or that have made some progress in their destructive career; but we often meet with other cases of an incipient nature, where the disease, although fully developed, is still in a quiescent or dormant state. In such cases I often accomplish a cure by means of absorption, giving no pain to the patient, and not injuring or removing any important part, as the breast, which must occur if the first mode of treatment is resorted to. Not only is this of use in incipient cancer, but I have seen it of much use when applied to the lymphatic glands, which had become secondarily affected. In such cases I remove the part primarily affected *en masse*, by means of the *sanguinaria* paste, applying at the same time the following ointment, spread upon cotton, over the enlarged gland or secondary tumor. This ointment is composed as follows, and called the brown ointment:—

R. Sulph: Zinci, ʒvi.

Sanguinaria, ʒij.

Myrica Cerifera, ʒj.

Extr: Opii (aquos.)

Ext: Conii, aa ʒvi.

Ungt: Cetacei, ʒvi.

Mist: et fiat ungt.

"In conjunction with this preparation, I use an ointment of the iodide of lead, generally applying each twelve hours alternately. The following is the formula used:—

R. Iod: Plumbi, ʒj.

Glycerine, ʒi.

Ungt: Cetacei, ʒij.

Fiat ungt.

"With a steady, persevering use of these two ointments I have often dispersed incipient tumors, which I have no doubt were cancerous.

"These are the external means of treatment I employ, which, although in themselves eminently successful, yet I am not content with them alone, but also pay particular attention to the general health, ordering a nourishing and sustaining diet, besides giving internally the puccoon, in small and repeated doses. A remedy that exerts so much influence when applied externally, must be exhibited with caution; I therefore seldom exceed half-grain doses, three times daily. This is given in the powder or decoction; in the former cases I give it either alone or combined with the sixteenth or twentieth of a grain of the iodide of arsenic and one grain of the extract of *cicuta*, made into a pill; or if given in decoction, I generally combine it with the fluid extract of *taraxacum*.

"The ointment of the sulphate of zinc I have been in the habit of applying, with marked success, in cancer of the womb. Unlike the Vienna paste, it can be applied, not only with safety, but with impunity, as it does no injury to the adjoining tender parts.

"I have also used these preparations, with marked benefit, in cases of lupus, both exedens and non-exedens; indeed I have never known a case in which the judicious use of these remedies has failed.

"Indolent ulcers have long been an opprobrium to the profession, from their intractable nature; in such cases these applications are most efficacious, as I have known phagedenic and indolent ulcers of long standing to be speedily and permanently cured in the course of two or three weeks. In such cases I have often accomplished a cure by using the *sanguinaria* alone, but even then I find much benefit in using the combinations as described in the above formulae."

On these details the Editor of the *Medical Times and Gazette* comments as follows:—

Now, first, as to the *Sanguinaria*. We have not the slightest hesitation in expressing our conviction that the *sanguinaria* has little or nothing to do with the results of the application, and that the chloride of zinc is the only active agent. The effects of the caustic, as de-

scribed by the surgeons of the Middlesex, are precisely those described by Canquoin, Maisonneuve, and others, who have used the chloride of zinc in paste in France; they are precisely those observed years ago by Sir Benjamin Brodie, and more lately by Mr. Haviland and Mr. Moullin, in this country; they are also very similar to those obtained by Mr. Stanley at St. Bartholomew's, by the use of dilute solutions of the chloride of zinc. The sanguinaria does not appear to be even as useful as the ranunculus and coltsfoot mixed with the arsenical paste used in the last century by Plunket and Guy. This had the effect of blistering the skin, and doing away with the necessity for cauterizing it with nitric acid, after the fashion of Dr. Fell; but the sanguinaria used in Dr. Fell's formula with the chloride of zinc, though it may possibly have some sedative or astringent action, is in all probability chiefly retained as a colouring matter, and as a drug not easily procurable in this country.

If, then, Dr. Fell's caustic be nothing new—nothing but the chloride of zinc so well known to all surgeons—we have to inquire whether there be anything in the mode of application for which Dr. Fell deserves any credit. He says his plan of incising the eschars and re-applying the caustic, in order to hasten its action, is “*believed to be entirely original*.” It is our duty to say, in plain terms, *it is not original*. It is an old method, well known to surgeons who are much in the habit of using caustics. It has even been applied to the very purpose of removing mammary cancers, just as Dr. Fell applies it. In the well-known pamphlet of Mr. Justamond, Surgeon to the Westminster Hospital, published in 1780, and found in all medical libraries, entitled “An Account of the Methods pursued in the Treatment of Cancers and Scirrhus Disorders and other Indurations,” this surgeon describes the method of removing the skin from over non-ulcerated cancers by “*lunar caustic*,” then applying an arsenical paste; and when the slough was beginning to separate, he says, “*in expectation of facilitating this separation, I made a few scarifications on the destroyed surface, and filled the crevices with some of the powder*.” So he goes on just as Dr. Fell does, only using arsenic instead of chloride of zinc, until “the gland came out as entire as the nut out of a shell, or as if it had been cleanly dissected with a knife.” Maisonneuve has long used the chloride of zinc in a manner even more effectual than this, by making long, narrow stylets of the chloride, mixed with flour and water, which, when dried, are pushed quite into the centre of malignant tumors.

We may therefore express our conviction, that neither in the caustic he uses, nor in his mode of applying it, is Dr. Fell entitled to the smallest credit.

This is not the place to discuss the relative merits of the knife or caustics in the removal of cancerous tumors, but we may express a very decided opinion, founded upon Dr. Fell's book, his own account of the cases he has treated, the report of the surgeons of the Middlesex Hospital, and our own observations of cases which had been under Dr. Fell's care, that the removal by his method is very tedious, often excessively painful, and, so far as any evidence has yet been offered, affording no more security against a reproduction of the disease than the more rapid and infinitely less painful use of the knife. In some exceptional cases, where the knife cannot be used with safety, or will not be submitted to, the chloride of zinc is deserving of more general application in this country.

REMOVAL OF THE NAUSEOUS TASTE OF COD-LIVER OIL.—We find, in the *Répertoire de Pharmacie*, that M. Leperdriel advises, to conceal the disagreeable taste of cod-liver oil, the addition to the latter of about ten per cent of common salt. Not only does the salt render the oil palatable, but it causes the stomach to digest the oil more completely. All the fish oils may be masked in the same manner.

POOR-LAW MEDICAL RELIEF.—From a return just printed, it appears that the acreage of the Poor-law medical districts in England and Wales, in 1854-55, was 34,423,530, the number of district medical officers 3,197, and the amount of annual salaries paid thereto £144,855.

THE EMPEROR OF THE FRENCH AND BARON HUMBOLDT.—The Emperor, wishing to honor science in the person of one of its most illustrious representatives, has just conferred on Baron Humboldt, by the hand of Prince Napoleon, now at Berlin, the dignity of Grand Cross of the Legion of Honour, the highest attainable grade in this order.

GENEROSITY OF M. CIVIALE.—Since 1829 there has existed at the *Hôpital Necker* a special department for the treatment of affections of the genito-urinary organs; and this has been now directed by M. Civiale gratuitously for nearly 30 years. Having good reason to fear that on his approaching retirement, for financial and other reasons, these beds would be given up, he has made over a sufficient sum of money to the hospital administration to secure their perpetual continuance, his successor receiving 1,500 francs per annum. In this way he hopes the improvements in lithotomy he has introduced may be continued by those who are to follow him; while a place for the succour of the indigent afflicted with this painful class of complaints, and for the instruction of young surgeons in the best means of relieving them, will be perpetuated.

ROYAL COLLEGE OF SURGEONS IN IRELAND.

At a meeting held on Monday, June 1st, the following gentlemen were elected officers for the ensuing year:

President—Hans Irvine.

Vice-President—James William Cusack.

Secretary of the College—Edward Hutton.

Council—Sir Philip Crampton, Alexander Read, Arthur Jacob, Thomas E. Beatty, William Hargrave, Andrew Ellis, Robert Williams, Robert Adams, James Barker, William Colles, John H. Power, James S. Hughes, Edward Hutton, Robert Pentland, Samuel S. Wilmot, Augustus E. Tabuteau, Aulay P. Bannoo, Peter Shannon, Rawdon M'Namara.

COMMUNICATIONS have been received from Dr. Barrington; Dr. Moore; Mr. Cadby; Dr. Johnston; Dr. Ledlie (Chicago); Dr. O'Donovan.

TO ADVERTISERS.

ADVERTISEMENTS will be received for the DUBLIN HOSPITAL GAZETTE by BROWNE & NOLAN, on the 12th and 28th of each month. The following is the

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A CASE OF ENDOCARDIAL DISEASE ARISING FROM INJURY,

AND ATTENDED WITH A REMARKABLE LOUD DOUBLE
MURMUR, &c.

By Dr. WILLIAM O'NEILL, M.B., Lincoln.

About fourteen months ago, a young farmer in company with his father called to consult me about a "distressing noise" in his chest, which had existed for the preceding sixteen or seventeen weeks. He gave me to understand that he had always enjoyed good health, never having had rheumatism or chest affection of any kind, till eighteen weeks previously. About that period he wished to drive a heifer from one field into another, but after a good deal of running, and many abortive attempts, he became a little irritated, and seized the animal by the tail, attempting with all his might to push her through the gate; but in the very act of doing so he was "struck" with a most intense pain in the left breast, followed by a sensation of deadly faintness. From that moment, he affirms, he had never been himself; for although the accident did not confine him to bed for more than a few days at the outset, yet from it he dated the uneasiness and palpitations of the heart which so much troubled him. About a fortnight subsequently he became aware of the noise; but as he happened at the time to be among shrubs, he thought it proceeded from something among the leaves; he very soon, however, traced it home to his own person.

Mr. B. was a remarkably fine young man, 23 years of age, above the middle height; had dark hair and eyes; was muscular; his looks, however, were anxious and careworn, and his nervous manner and questions about his state, indicated very plainly how heavily the disease sat upon his mind. But that which quickly forced itself on the observer's attention, was his peculiar mode of progression: he stooped in a curious hooked manner; walked cautiously, moving the upper part of his body as little as possible. He did not complain

of cough. Respiration was slightly hurried, but that was owing partly, I think, to his unwillingness to hold himself erect, and fully to expand the chest. The pulse was 84, and might be said to be regular whilst the patient remained quiet, but became slightly irregular on exertion. He complained of occasional shooting pains in the chest, and of a tightness over the heart. He never had any head symptoms, and his digestion was good.

In making a physical examination of the chest, the lungs were found healthy. In the precordial region there was neither fremitus to be felt, nor bulging to be seen; on the contrary, that region seemed flatter and more immoveable than natural. The area of precordial dulness was slightly increased, and its limits remained the same in expiration and inspiration. Whilst at rest, the heart's action was normal, or nearly so; but when excited, its movements and impulse corresponded to the pulse at the wrist—that is, occasionally irregular in force and frequency. From about two square inches of the precordial region, inclining more towards the apex than base of the heart, the loudest conceivable endocardial murmur proceeded. It was very superficial and double, and when standing a few feet from the patient (and I may add that it could be heard six feet from him), its tone was that of the loudest rasping bellows-murmur of aortic patency. In the precordia it was quite impossible to hear the heart's sounds on account of it; and indeed to whatever part of the chest the ear was applied, the sound haunted it, engrossing all attention with its disagreeable rasping.

Whilst wondering at the magnitude of the murmur, I inadvertently placed the patient on his back, when, lo! it was gone, without leaving a trace behind; and now the sounds of the heart could be heard with all the characteristics of health. I raised him to the sitting posture, and found it had returned again—replaced him recumbent and extinguished it. These manœuvres I repeated several times with the same results. Mr. B. now informed me that he had very early discovered that lying on his back, and to a certain extent on his sides, freed him from his tormentor;

and these positions he was wont to assume whenever he had an opportunity.

Mr. B. now went to the Continent, where he remained for more than a year, having been advised to go thither by those who thought the chief part of his ailment was nervous, and that if travelling would not cure him, it would materially benefit him. I have been lately told, however, that he is about returning home not improved.

The preceding case is, I think, one of considerable interest. And firstly, as to the cause; there can be but little doubt that the origin of the disease was some valvular lesion which took place at the moment when he was struck with the acute pain in the side. It seems extraordinary then, that after a lesion ushered in with such severe symptoms, as "most intense pain and deadly faintness," the patient should so soon be enabled to resume his ordinary occupations.

It is also worthy of observation, the length of time which elapsed between the lesion and the patient being sensible of the noise emanating from his chest; also the characters of the murmur, its intensity, its easy demolition, and its constant recurrence. When I saw the patient the murmur had existed fully sixteen weeks; and I examined him twice carefully, with an interval of a week between each observation, and on comparing the notes I took each time, they were found identical. What is the true reading of the case in this instance? The fact of the murmur being double proves that it is combined with regurgitation of the blood, and from its not becoming developed for some time after the accident, it is manifest that it had not its immediate origin in the lesion which then took place. I am inclined to the opinion that the accident gave rise to a laceration of one of the aortic valves, from which the patient suffered slightly, and lay in bed for some days; but in the process of healing, a large shred of lymph or fibrinous matter was developed at the edge of the valve, and, being somewhat loose, was tossed up and down in the current of the blood, and gave rise to the loud *double* murmur. When the patient lay down, this loose fibrinous matter was received into some bed or recess, into which it fitted; and when it was no longer agitated in the current of the blood, the bruit ceased.

Thus much of this very interesting case has been written for some time past, but I deferred the publication of it when I heard that Mr. B. was returning from the Continent, as I hoped to be able to subjoin a report of his present state.

On Saturday, May 9, I had the gratification of again seeing Mr. B. In appearance he is much changed, having become thin and anæmic, and so nervous that when he saw me he shook all over. Time has so changed the character and intensity of the sound, that valvular disease of the aorta is now quite obvious. Instead of the rushing, creaking murmur, there is at present a smooth, musical double-bruit, but still so loud that it can be heard a foot or more from the chest. It is most in-

tense, however, over the upper third of the sternum, from whence it diverges all over the chest and up the neck; but as before, all is silent when he lies on his back. The only phenomena then observable are a slight flattening and immobility of the precordial region: this flattening, however, may be more apparent than real, and be caused by the constrained position in which he invariably holds himself, and from his breathing less with the left lung than with the right. Whatever may be the cause of it, it is plainly perceptible. The heart's action is good and regular, and there is no visible pulsation in the arterial system. He has no cough, but complains of indigestion, and frightful dreams which distract his sleep very much. He had hæmorrhage from the stomach and bowels, six or eight months ago, which accounts for his great anæmia. He spoke with evident delight of having, in a great measure, lost the noise in his chest, and the palpitations, which made him so miserable.

ON THE VALUE OF LEMON-JUICE AND ACETATE OF POTASH, IN THE TREATMENT OF ACUTE RHEUMATISM AND GOUT.

By WILLIAM MOORE, M.B. T.C.D., M.R.I.A.

Lecturer on Materia Medica and Therapeutics in the Dublin School of Medicine, and one of the Physicians to the Institution for Diseases of Children, Pitt-st.

In this country the exciting cause of rheumatic affections in general is usually attributable to damp in some form, particularly to the moist winds and mists of November and December. The north-west wind, which chiefly prevails at this season, blowing off the Atlantic ocean, is loaded with damp, and this country, acting as a break, receives its share in no mean degree. Spring is peculiarly obnoxious to rheumatic and neuralgic seizures, which I should attribute, in great measure, to the prevalence of keen east winds, usually blowing uninterruptedly for the months of March, April, and half of May. In summer we meet with cases of acute rheumatism, generally occurring in young persons, from sudden checking of the secretions, viz., from indiscretion in bathing, or indulging in cold drinks whilst over-heated.

In these latter cases the disease is met with in its most aggravated form, and complications, especially pericardial and endocardial, are frequent, leaving the nidus for future mischief, which is added to by a repetition of the attack, in the majority of cases rather the rule than the exception.

A gentleman, aged about 38 years, of active temperament—unceasing assiduity in the pursuits of a laborious profession, which entailed almost constant confinement and sedentary habits—consulted me some time since. He looked dejected and unstrung, and he told me that he had been suffering from an ulcerated sore throat, for which

he had been actively dosed with blue pill, and other aperient medicines. He fancied himself still bilious, and had repeated the blue pill dosing previous to my seeing him, but without any good effect. Finding him anæmic and dejected, I prescribed an infusion of bark, to be taken three or four times during the day, and ordered Hydrarg: c. cretâ et Pulv: Jacobi, every third night, as a mild alterative. The first day following the exhibition of the bark, the patient stated he felt rather better, but his general appearance did not confirm this statement.

The next day, the 31st January, I found him unable to go about, from a very acute pain in the left hip-joint and groin. The right ankle was also painful, and slightly swollen. Pulse 100 and hard; tongue dry; papillæ prominent; eyes heavy; sclerotic coat yellowish—every evidence of constitutional disturbance. Omit the Infus. Cinchonæ.

9 p. m.—Patient unable to move from pain in the hip-joint; urine scanty, not depositing any sediment; pulse quick; slight thirst. On examining the heart, a bruit is audible with the first sound, indistinct with the second; slight perceptible dulness over the precordial region. Prescribed Hydrarg: c. cretâ, and Pulv: Jacobi, to be followed by a saline aperient, in the morning.

1st February.—The patient passed a restless night; pulse quick and hard; urine still scanty, no sediment deposited. I satisfied myself more particularly as to the presence of the bruit, which accompanied both sounds of the heart; was most marked with the first; and from the history of the patient, who states that he has felt a dull aching pain frequently about the region of the heart, and occasionally has observed a fulness about his ankles at bed-time, I fear that the mischief has been in existence, though latent, for some time; at present there is no precordial uneasiness, no palpitation, no dyspnoea, or cough. Pulse 100; profuse acid perspiration. The second sound of the heart seemed slightly masked, and the bruit is prolonged over the course of the aorta. I ordered him Hydrarg: c. cretâ and Pulv: Ipecac: Comp. at bed-time, and Bicarb. Sodæ in effervescence with lemon-juice, *ad libitum*; low diet.

2nd February.—Patient restless and uneasy; had passed a bad night; urine very scanty; pulse 100, not so bounding; tongue rough, but not much furred; pains in the left knee and hip-joint severe, but more distressing in the shoulder-joints; bruit audible; perspiration profuse. Ordered him a table-spoonful of free lemon-juice, every third hour, with the effervescing mixture as before, and repeated the Pulv: Ipecac: O. et Hydrarg: c. cretâ, at bed-time.

3rd.—Patient greatly depressed, and exacerbations of pain more frequent; tongue more furred; pulse 100, not so hard; complains of pain in the ankle and shoulder joints; left ankle much swollen; bruit still present, but not more distinct; can lie on both sides; has no cough, no dyspnoea, no

palpitation; bowels have been freely acted on. The mercury was omitted. Continue the Pulv: Ipecac: comp. at bed-time, and the lemon-juice free and in effervescence as before.

4th.—On the whole my patient is easier, though he did not rest well; the ankle and hip-joints most painful; pulse 96; urine loaded with lithates. Spirit of nitrous ether was added to the effervescing mixture. Lemon-juice as before.

5th.—Patient's general appearance improved; less thirst; pulse 90; bowels have been well acted on; passed a better night than the previous one; hip-joints very painful; shoulders easier, and can make more use of them.

6th.—I found this gentleman had passed a quiet night; pulse a little more excited; bowels sparingly acted on; pain in the hip-joint extreme. I enjoined perfect quiet, and avoidance of excitement. The mercury to be resumed at bed-time, with the Dover's powder.

7th.—Patient on the whole easier; bowels have been freely acted on; pulse 86; bruit very indistinct, especially with the second sound. At 9 p.m. found his pulse 82. I ordered him Infus: Cinchonæ, and Sodæ Carb. in effervescence with lemon-juice.

8th.—Pulse 82. Add ℥iii of Acetate of Potash to the mixture of bark; omit the Hydrarg: c. cretâ; continue the Pulv: Ipecac: O. at bed-time. Pains in all the joints much easier; bruit indistinct.

9th.—The improvement of the preceding day in every respect confirmed; convalescence considered to be established.

On the 10th he became excited; his pulse rose to 90; the bruit became more audible; and there was a general accession of the fever. On inquiry I found that presuming on his improved condition, he had transacted business of a most anxious character, and had received a "levee" of visitors after my leaving him. Suffice to say I found him in a state of relapse, and again resumed the lemon-juice. Sir Henry Marsh now saw this case. He considered the origin of the bruit to be of some standing, and advised to continue the lemon-juice treatment.

I find on the 16th February, the pulse again 80, bruit scarcely audible, with general improvement. This was more fully established on the 17th, and the patient had now an uninterrupted convalescence.

In this case we had acute rheumatism with high fever manifesting itself on the 31st January, and on the 8th February convalescence apparently established, as was evidenced by the pulse, and improvement in all the secretions; this was still further carried out on the 9th, so that under the free use of lemon-juice, with an alterative and opiate at bed-time, the case did well on the ninth day. On the evening of the 9th and morning of the 10th, from excitement and indiscretion of no ordinary amount, fever was again induced, the "cardiac bruit" became more audible—in short, a complete

relapse ensued. The same treatment was persevered in, and again on the 16th February, the patient had rested well; "bruit," though still present, was indistinct. On the 17th we had the pulse again at 80, and all other symptoms on a par. Convalescence was now rapid. This gentleman took at least from eight to ten ounces of lemon-juice, in various forms, during the twenty-four hours. As regards the affection of the heart, I believe it had been in existence previous to this attack, which merely developed it more fully. The patient has felt an occasional tumbling sensation at times, with palpitation, especially after long-continued professional excitement, which he was much exposed to in various public capacities. When he left for the country (about the end of February), the "bruit" was scarcely perceptible. I believe this to be one of those cases in which Dr. Stokes considers valvular disease may have existed, without development of murmur, until from some circumstance, either inflammation, mental excitement, or the use of stimuli, the heart becomes excited, and then valvular murmur is developed.

The next case in which I used the lemon-juice was that of a young man, aged 19 years, a farm servant. He had rheumatic fever of a very sthenic character; the large joints principally affected. He had increased action of the heart, but no murmur. In the early stage I commenced the treatment of this case with brisk purgatives and opiates at bed-time. On the fourth day I changed my treatment to lemon-juice *per se*, and in the form of lemonade; no opiates. The most marked improvement ensued, and the case did well on the twelfth day. I feel satisfied, from the specific action of the lemon-juice in this instance, that some time was lost in the early stage of the treatment of this case.

Case 3 was one of acute gout. In the spring of 1854 I was asked to visit Mr. — aged 50, a stout plethoric man, whose habits in early life had been, at times, somewhat irregular. For the last few years he has been suffering from periodic attacks of gout, which latterly have been returning more frequently. I saw him in conjunction with his ordinary medical attendant, suffering from pain and swelling of the smaller joints, with great constitutional disturbance, the attack having been ushered in with severe bilious vomiting. The urine was scanty, and loaded with urates; he had been freely dosed with blue pill and James's powder previous to my seeing him, and in former attacks had taken colchicum. I proposed lemon-juice, half an ounce to be taken every third hour. The happiest results attended this treatment from the very beginning.

I do not mean to advocate this specific mode of treatment in all cases of acute rheumatism and gout, having seen cases where it was equally carefully exhibited, and no apparent good resulted. The following mode of treatment I should be inclined to adopt in these cases where we must

naturally conclude that the portal system is implicated. Exhibit a brisk mercurial alterative and purgative, blue pill, or calomel, with compound rhubarb pill, and dried soda. This treatment may be indicated at intervals during the course of the disease, more particularly during an attack of acute gout. When the bowels have been freely acted on, I prescribe the lemon-juice, in the proportion of a tea-spoonful or dessert-spoonful, according to the age and calibre of the patient, every second hour, for the first forty-eight hours, and if its sedative effects manifest themselves so early, I continue the same treatment; should there be no change observable, I increase the dose in the case of an adult, to half an ounce every third hour, with lemonade *ad libitum*. In cases where this plan of treatment seems to act specifically, amongst its other good qualities it tends to keep the bowels, as well as the other emunctories, free, and thereby lessens a source of annoyance both to the patient and practitioner, which other forms of treatment tend rather to aggravate. Occasionally we meet with cases in which the sedative effects of lemon-juice are well exemplified during the night also, but as a rule, I should be inclined to give from fifteen to thirty minims, according to the age of the patient, of the solution of muriate of morphia, same strength as laudanum, at bed-time.

The acetate of potash is deserving of great attention in the treatment of acute rheumatism, either *per se* or combined with lemon-juice; largely diluted it is a decided diuretic and laxative. I have prescribed it in many cases of rheumatism, generally in combination with lemon-juice, and with good effect. Dr. Sandwith, of the Hall Infirmary, recently treated ten cases of rheumatic fever with acetate of potash, and with unusual success. He thinks its superiority consists in the rapidity of its action as a febrifuge, which is probably owing to its power in carrying off from the blood the specific poison which has excited the febrile commotion. He premised a suitable cholagogue of calomel, followed by a rhubarb or *senes* draught, when he suspected portal congestion, as shewn by arrest of the biliary and urinary secretions; after this he employed acetate potash $\mathfrak{z}\text{i}$ to $\mathfrak{z}\text{ii}$, dissolved in half a pint of water, with the addition of a little lemon-juice and syrup, to be drunk during the day. Under this plan of treatment, three cases were cured in seven days, one in ten days, one in thirteen days, one in fourteen days, one in fifteen days, two in seventeen days, one in twenty days. He goes on to state that in the above cases there was no endocarditis, so that we may hope that a further trial of this remedy will show its power in resisting this fearful complication. Dr. S. employed the acetate of potash in chronic rheumatism, with marked advantage. I recently read, with great satisfaction, Dr. Garrod's cases, treated with bicarb. potassæ, in doses of $\mathfrak{z}\text{i}$ to $\mathfrak{z}\text{ii}$, every second or third hour; but I regret to say I have not had an opportunity of trying this treat-

ment; at the same time I have been assured that it has not proved equally successful in the hands of some of our most eminent physicians here.

As regards the local treatment in these cases, leeches to the inflamed part are seldom required; I prefer the more soothing applications, as raw cotton, or anodyne fomentations. In gout, spirit of wine has been much lauded, as also alkaline poultices; but I think, in the majority of cases, the application of a weak tepid solution of spirit and water (1 part to 4) will be most grateful to our patients.

MEATH HOSPITAL.

CASE OF PURPURA HÆMORRHAGICA.

By C. LEES, M.D.

Physician to the Hospital, &c., &c.

(Reported by Mr. CALES SHERA WILLS, Clinical Practising Pupil.)

Mary Farrell, æt. 22, single, a servant, was admitted into the Meath Hospital, on the 2nd March, 1857.

She states that her general health has always been good; appetite unimpaired; lived well, with a full allowance of animal and vegetable food. Since the catamenia first appeared, when 17 years old, she has suffered from almost complete amenorrhœa, being very frequently six or seven months without the menstrual discharge appearing, and then very scanty; but when the menstrual period would arrive and no discharge, she suffered from headache, pain in back and loins; these disappearing in two or three days. She had no menstrual discharge for six months previous to three weeks ago, at which time it returned, but being scanty as usual. A week after this she caught cold, had cough and expectoration, and complained of general lassitude, with pain in head and back. She continued so till Saturday, 7th March, when she was attacked with nausea, vomiting, rigors, and increased pain in the head. Next day she felt extremely heavy, and observed three dark spots on the right side of her neck. She continued to work, and on Monday morning early, while cleaning furniture, she had severe epistaxis; immediately after her gums began to bleed. The hæmorrhage from nose and gums continued during the day, but she did nothing for it. On Tuesday hæmatemesis occurred, the blood being in considerable quantity, dark and fluid. On the same night she "was almost smothered" by the blood trickling into her throat from the nose and gums. At this time she began to experience an uneasy sensation of tightness or constriction about the chest. Wednesday morning she found her whole body covered with red spots; the constriction about the chest continued. She then left her situation, and went home. She passed about a pint of fluid and pure blood by the bowels on Tuesday and Wednesday; and on Thurs-

day she found her urine bloody. There was no hæmoptysis, nor hæmorrhage from the uterus. The constriction about her neck and chest, the hæmatemesis and hæmaturia continuing unrelieved, she was taken into hospital on Thursday afternoon.

She is a full, strong, healthy-looking person, florid complexion, sandy hair, and grey eyes. Face flushed, skin hot, though she complains of cold, and is shivering. There is a large patch of extravasated blood at outer canthus of each eye, beneath conjunctiva; the surface of her body is studded over with minute red spots, intermingled with some of larger size and purple colour; they are more numerous on neck, chest, and lower extremities, than elsewhere; do not disappear on pressure. The small, florid spots, are smooth and on a level with the skin; but the large, dark ones are *raised above its surface, and feel rough*. There are a few minute specks on her face, but very large and numerous all round her neck. On the lower extremities are three or four livid spots as large as a shilling.

She has severe pain in head, which feels light when she sits up; lips and teeth are covered with dark coagulated blood; gums slightly spongy; tongue large, flabby, and streaked with blood; great thirst; anorexia; lungs healthy; no cough; heart's action normal, sounds healthy; pulse 72, soft and regular; abdomen tense, and slightly tumid, especially in the right hypochondrium, which is tender; and there is some enlargement of the liver; bowels constipated; urine bloody, amount secreted natural, specific gravity 1.012; blood globules and triple phosphates evident under the microscope; no casts of the tubes; no pain or swelling in any of the joints.

R. Pulv: Secal: Cornut: ði. ft. pulvis quartâ quâque horâ sumendus.

14th March.—Rested well; no hæmorrhage, except a slight oozing from gums, and hæmaturia; headache severe; pains in back and bones; conjunctivæ slightly tinged with yellow; no change in character of petechiæ; pulse 80, regular; some cough; no expectoration; abdomen tense and tender; bowels constipated; urine bloody, acid reaction; no triple-phosphates.

*R. Pil: Hydrarg: gr. iii.
Pil: Rhosi: Co: gr. v.
M. ft. Pil: ij. h.s.s.*

*R. Sulphatis Magnesie ʒi.
Acidi Sulph: dil. ʒi.
Infusi Rosarum, ʒvi.
M. capt: ʒii, p.r.n.*

Beef-tea (cold) and solution of cream of tartar for drink.

16th March.—No hæmorrhage since; no blood in urine to-day, which deposits lithates; but headache very severe; pains all over body, and complains of cold; vomited several times since yesterday; pulse is quiet; bowels open.

Omit ergot of rye, and to get the following—:

R. Acidi Gallici 3ss in Pil. vi.
Capiat i. tertia quaque hora.

17th March.—Much better; slept well; very little headache; pains all gone; yellowness almost disappeared from conjunctivæ; tongue clean and moist; no sponginess of gums; no cough; heart normal; pulse 80, regular; bowels regular; urine quite healthy; very slight bleeding from nose. Continue treatment as before.

18th March.—Improving; no hæmorrhage of any sort; no headache; face bright and cheerful; tongue moist and furred; pulse 76, regular; petechiæ beginning to fade, with yellow and green areolæ around the dark centre; liver more enlarged and painful on pressure; bowels regular, fæces natural; urine amber-coloured, acid reaction; appetite returning, and thirst less. Treatment continued.

19th March.—Slept well; countenance animated; appetite good; no thirst; pulse 68, soft and full; region of liver painful on pressure; petechiæ fading, but there is a *central white spot on each*, except in one or two large ecchymoses on legs; this appearance first presented itself to-day.

To get an aperient draught, and repeat pills.

27th March.—Feels perfectly well; a few spots just discernable on neck and legs; no tenderness in region of liver, but abdomen still continues somewhat distended. Menstrual discharge has not yet re-appeared.

She now left the hospital apparently perfectly well.

In the *Gazette* of November, 1854, I published some cases of hæmorrhage from the bowels, lungs, and nose, in which I had used the ergot of rye with success, and I think the above case is worth adding to the list, as this medicine appeared to exert a decided and speedy influence in controlling the tendency to hæmorrhage, especially that from the urinary organs, which at first was very alarming from its great quantity. This case exemplifies one objection to its use, namely, vomiting, which, however, ceased on the medicine being omitted; and the gallic acid then acted well in repressing any further tendency to hæmorrhage. The chief points of interest in the case were, first, the cause of the hæmorrhage, for the girl was robust and healthy-looking, was well lodged and fed, so that I think the morbid condition of the blood must have been owing, in the first instance, to the derangement in the uterine system as a remote cause, and then the hæmorrhagic tendency was called into action by some influence of the portal system, as evidenced by the congested state of the liver, and so far appears to favour the opinion of Dr. Williams,* that purpura may be referred to "defective elimination of effete matter, and is

often connected with hepatic congestion, and imperfect secretion of bile." This case also proves that the fibrine is not deficient in acute purpura hæmorrhagica, as the prominent spots felt under the skin were evidently caused by the effused blood being firmly coagulated. And the central white spots in each of the effusions is also worth noticing, as I am not aware of their having been previously observed. It is an interesting fact in the history of these cases of hæmorrhagic diathesis, that there is seldom any delirium or disturbance of the intellect, as if this peculiar condition of the blood was caused by the direct agency of the morbid poison on the circulating fluid, leaving the brain and nervous system untouched.

Proceedings of Societies.

BELFAST CLINICO-PATHOLOGICAL SOCIETY.

ADDRESS DELIVERED BY DR. M'GEE, PRESIDENT,
At the close of the Session, 1st May, 1857.

GENTLEMEN,—In my inaugural address I brought under your notice some of the more important duties of the physician, and I have selected, as the subject of my present discourse, the progress of science during the present century, more especially of medical science, and its collateral or allied branches. Progress, which, like the river flood, ever rolling onward, ceases not to swell till it overflow and fertilize the thirsty, barren land it passes over—progress, than which, of all the laws stamped on the universe, we shall find none more deeply impressed.

Those who love to trace back the spring of all knowledge to ancient days, believe that it had its source in the East, and flowed thence, with a fertilizing current, westward: and true to the spirit of the *Laudator temporis acti*—they dwell on the glories of bygone days—lament how degenerate we have become: and pointing to the poets, painters, sculptors, orators, dramatists, historians, philosophers and physicians, of Egypt, Greece, and Rome, they ask, where in these days we can find an equal to the men of note who then flourished? It is true they were giants in their time, yet we also can boast of the celebrities of our days.

If, in this onward march every where observable, mental science has, as some assert, made less progress than physical science, it is chiefly owing to the more attractive character of the latter branch; still we cannot fail to observe the mutual dependence of all departments; for we shall find none that does not give to, and receive from, every other department, material aid, thus forming, when united, one firm chain, every link of which is of importance to their common bond of union.

It would be to take a very narrow view, if we classed, for instance, natural philosophy and chemistry, as subjects merely of amusement, or relaxation from other studies. There are few of the later discoveries, in these departments, that

* Principles of Medicine, third edition, pp. 138.

cannot be shewn to be of primary importance in promoting the health or the worldly comfort of man.

How ennobling to the name of Davy has been his safety lamp? Of less brilliant pretensions, yet of much value to the artisan, is the simple but effectual means of preventing that fatal disease, "the dry grinders' rot," viz., the use of the magnet, which arrests the fine steel dust, formerly inhaled; in short, I may ask, what art or trade has not been benefitted by chemistry or natural philosophy?

In our own department, the anatomist is indebted to the microscope for his knowledge of the minute structure of tissues, healthy as well as diseased. Again, when some careless observer shall inquire how the discovery of the polarization of light, which he views as a mere amusing trifle, can possibly benefit man, to those who are in the habit of using the microscope, the value, indeed the necessity, in certain cases, is well known; but on a more important point, let us hear what Arago says. He has shown that polarized light, which is contained in the moon's rays, in the light from the clouds, and in all reflected light, carbonizes, while direct light oxygenates; hence the unhealthy effects of the light in the dwellings of the poor, situated in narrow alleys, reflected from opposite walls, as compared with direct light. But not alone does the kind and amount of light enter materially into the sanitary condition of dwellings, but colour also must now be considered an important agent. (Dr. M'Gee here referred to an article in the *Dublin Medical Press*, shewing that rooms coloured yellow were productive of disease among the inmates, which disappeared on the white-washing of the walls; and he observed in confirmation of the theory, and as a proof that it was not a mere coincidence, the effect of yellow light in preparing for photography).

Again, where it is proved to us that the electric, galvanic, and magnetic fluids, and even highly concentrated steam, are identical, we must not consider such knowledge as unimportant. Scoresby, that ardent votary of science, made a voyage of 30,000 miles, out and home, for the sole purpose of testing his theory of magnetic deviation on ship-board, thus benefitting man as regards navigation; then in furtherance of physiology, we find Dr. Radcliffe asserting, as the result of actual experiment, that an electric current exists in a muscle of the body during rest, and ceases during contraction; that then, as also during cadaveric rigidity, the needle of the galvanometer stands at zero, and that it is by neutralizing the already existing natural electric current, that artificial electric currents produce contractions in a limb.

It would be to prolong this single question of magnetism or electricity to an infinite extent, if I entered on the various modes of generating those powers, or the laws that govern them; hereafter I perhaps will refer to some of their uses.

In natural history we find some lessons of importance; among the many that press on us, and injuriously affect our interests, I may remind you of the Tania, and *Oysticerus Cellulosus*, and their transformations; and the student of skin diseases will have brought vividly before him the vegetable and animal parasites.

Yet, notwithstanding all the benefits she has conferred, science has been accused of fostering crime, by the facilities afforded for its perpetration; in her defence we can plead that science has deprived the criminal of all reasonable chance of escaping with impunity.

The electric telegraph enabled the officer of justice to arrest in his flight, and bring to punishment, the murderer Tawell. The microscope, by its revelations, gave the clue to the detection of the gold dust robbery, and enabled the observer to prove the forgeries of the *Uranian Manuscripts*; and if last, certainly not least among its triumphs, the microscope has shewn forth, in all their enormity, the food and drug adulterations. Photography has, with other discoveries, in some degree aided the forger in victimizing the unwary; but in return, as has been well observed, "it takes and multiplies the felon's portrait, and so insures his capture." Chemistry may aid, and may have aided the secret poisoner, in effecting, with some degree of certainty, his wicked designs: but it has done much to lessen his hope of escape; and the question of Hamlet, "How long will a man lie i' th' earth ere he rot?" would now receive a different reply from the philosophizing grave-digger, and it would not be merely, "I faith, if he be not rotten ere he die, he will last you some eight or nine year. A tanner will last you nine years; for his hide is so tanned with his trade, that he will keep out water a great while;" for we know now that some poisons serve, as it were, to embalm their victims, and so secure evidence for the conviction of the murderer.

If Marshall Hall had in no other way benefitted science, his application of the frog as a strychnometer, as well as a galvanometer, would immortalize him. He thus detected $\frac{1}{3500}$ part of a grain of acetate of strychnia.

In considering what are the qualifications requisite for an accomplished physician, it is manifest he should be sufficiently well acquainted, not with languages alone, but with general science; a man not merely of one idea, or devoted entirely to medical pursuits, in the ordinary sense of the word; but a man of varied accomplishments and enlarged ideas. Currie of Liverpool was not less estimable as a physician, or Charles Bell as an anatomist and surgeon, because they travelled into the field of literature and general science; and our profession can boast of many such ornaments.

Medical science, like a goodly tree, spreading far and wide, and drawing life and strength from every quarter, despises not the aid and support

afforded by the humblest plant, repaying by its shelter, when at maturity, the aid formerly lent to it. Closely connected, as it is, with its allied branches, it would be difficult to draw the line of demarcation, and say that here or there the province of the physician ends, and that of the anatomist, or surgeon, or chemist begins.

Medicine, as a science, has had many difficulties to contend with, which have retarded its progress. Of these difficulties, the most obstructive, perhaps, has been the system of theorizing. It has been urged that there have been more false facts than false theories; perhaps people should rather say, "ingenious theories, that make the meat they feed on." Be that as it may, we cannot but feel that the theories of spasm, the Brunonian theory, the theory of inflammation, and many others, have been the drag on the wheel of science. These, and various other theories, which sank as rapidly as they rose, failed because they were applied each as a *master-key* to unlock every door. We have seen some sink, to rise again with greater brightness; and in reviewing the history of medicine, nothing can be more strange than that of the Humoral pathology; this for a time exploded and forgotten doctrine, has again appeared, and we have clearly displayed by the aid of chemistry and natural philosophy, through the microscope and chemical analysis, facts of which the Humoral pathologists, in days of yore, got but an indistinct glimpse. Many late discoveries confirm the truthfulness of the Humoral or Blood Pathology. I may here instance, as the result of medical research, amyloid, or starch degeneration, fatty degeneration, pyæmia, nræmia, Bright's and Addison's diseases, the intimate and almost necessary connection between certain diseases, or diseases of certain organs, as for instance, heart, brain, and kidneys; and the diagnosis between the idiopathic and symptomatic forms of some ailments, may be classed among the valuable labours of our physicians. I will merely name the now almost settled question of the non-identity of typhoid and typhus fever—a question all important, and leading to some important pathological results; simply observing that Professor Huss, of Stockholm, dissents from the opinions of Lonis and Jenner.

In mental disease, though the moral and non-restraint system have done much, yet the labours of William Tuke, the quaker, and his cotemporary Pinel, leave much still to be effected.

Industrial pathology, in addition to the instances already quoted, has to acknowledge many other boons that she has received from the chemist; in illustration I have to refer to the proposition of Liebig, who would prevent lead colic by keeping the men engaged in lead manufactories charged, so to speak, with sulphurous acid.

Vital statistics and medicine mutually act and re-act on each other; and people are now, from witnessing the results of statistical returns, forced to admit that the influence of offensive and ob-

jectionable trades operates powerfully on health, and on the duration of life; and that they are indebted to the physician for the evidence that famine and pestilence stand in the relation of cause and effect.

The statement put forth that many of our sufferings are self-inflicted—that much of the disease men labour under, especially of the class termed zymotic, a name of itself conveying much to our minds—that a large portion of the ailments that are daily and hourly shortening the brief span of our existence, is preventable, *startles* us; but does it lead us to adopt preventive measures?

Have the statements again and again trumpeted in our ears, that when disease visits the cottage of the poor, it seldom passes by without leaving a summons at the palace of the rich, made any change in our plodding policy? But if men are to be guided only by mere money considerations—by the *argumentum ad crumenam*—then, in following up the financial view of the subject, we may remind all such that preventable disease does much to fill our workhouses; and it might be worthy inquiry what cost the death of one head of a family entails on the poor-rate.

I will not detain you with the history of the sanitary reform movement, lately roused to a state of active progress by the efforts of some benevolent but bold men—men earnest in carrying out their honest views, bold in setting at naught public ridicule, and persevering in their efforts to induce others to join their ranks; but I must claim for my medical brethren of the army and navy, the merit of being the pioneers in leading what might then be considered a forlorn hope against existing evils. I give due credit to Howard, who carried into active operation, in civil life, the suggestions given by the example of our military and naval surgeons.

The labours, in late days, of Southwood Smith, Chadwick, Arnott, Kay, and Gavin, are now matters of medical history; and the "Enquiry into the condition of the Dwellings of the Poor," and "Snow's Researches," are no mean additions to our medical literature.

I cannot, however, pass by in silence the important data as to the statistics and geography of disease, supplied by the reports and returns of our naval and military surgeons. By them we are instructed as to the influence of season, locality, temperature, latitude, age, and even diet, in the production of disease; thus following up the observations of Humboldt as to the effects of mere altitude in checking yellow fever. By these returns we find that while some diseases prevail only in certain zones and isothermal lines, others are ubiquitous. We moreover now know that human epidemics are coincident with, or follow close upon, if they are not governed by epidemics among the lower animals. Again we are reminded, in our sanitary measures, when warned by offensive smells, not to be satisfied with the removal of the odour, but to

remove the cause also; and not to consider deodorizers and disinfectants identical. The using a mere deodorizer has been quaintly compared to the "putting a clean shirt over a dirty skin."

The physiologist, far from idle, has taken a first-class place in the race. We have had produced to us the nerve theories—not mere theories—of Charles Bell, and Marshall Hall, and Browne-Sequard, ardent and devoted labourers in the field of nature. Our present knowledge of the structure, and functions of the pancreas, spleen, liver, and perhaps of the supra-renal capsules also, is tolerably correct; and among the latest additions to our stock of knowledge is Richardson's discovery of the cause, or supposed cause, of the coagulation of the blood.

Medicine has had vast and important additions made to its list of therapeutic agents; and I shall only contrast the mode of curing intermittent fever proposed by Mathew Henshaw in 1677—viz, the condensing or attenuating, as required, the air in a chamber, at the same time ventilating by the action of common organ bellows, with the use of quina. The merest tyro would deem me trifling if I mentioned cod-liver oil; but the most remarkable propositions we have had placed before us are, "the Ready Method" of Marshall Hall, for restoring suspended animation, and his tracheotomy in some forms of epilepsy.

Looking back to the state of chemistry at the beginning of the present century, and then considering what we have since had revealed to us, we find a state of things setting at defiance nearly all our preconceived opinions. We find the earths and alkalies of those days now proved to be metals.

We see metals no longer distinguishable by ponderosity, or almost any of their former characteristics. We know that many of the bodies, then considered elementary, are not only compound, but have actually been resolved into what we, for the present, believe to be their primary elements. Can we be certain that the voltaic pile has revealed to us all the wonders of creation? Who will now venture to assert that other and more powerful agents will not be discovered, enabling future chemists to outrival Davy and his compeers? Can we be assured that even one of our gases, hydrogen, is not really a metal? There are some analogies that make the idea more than possible. We have seen, in our times, strange metamorphoses: We have seen common clay, or rather its alumina, converted into a metal, brilliant, sonorous to a high degree, ductile, malleable, not easily oxydizable by the atmosphere, and non-magnetic. It was originally obtained from cryolite, a Greenland mineral, but its present price is not much above the price of silver, while its specific gravity is much less. Sanguine chemists express a belief that aluminium will be produced from clay, at a price as low as that of iron. Should this belief prove well-founded, what a revolution may be thereby produced, especially in ship building, aluminium being non-mag-

netic. Chemistry has taught us, not only how to separate or divide compound bodies into their primary elements, but also to combine and form, or reform, some substances from their elements; and here it is that the atomic theory of Dalton has done good service. Oil of mustard and taurine have been thus produced; and Daubeny, last year, announced the formation of several species of alcohol from coal gas, and the manufacture from guano of a beautiful crimson, rivalling cochineal; but you are aware that alloxan, with its rose-colour, ranging up even to deep crimson, and murexid, both obtained from guano, are products derived from uric acid, one of its constituents.

In science, names have not always been correct definitions of things. We now find chemistry rendering one name appropriate, inasmuch as photographs are now, or *may* now be light writings, instead of necessarily being sun pictures; they may now be produced by powerful artificial light, as that from sulphur burned in oxygen, or from phosphorus.

Chemistry has given material aid to the physician in his inquiries; has enabled him to verify Bright's discoveries, and to demonstrate, not only the existence of glucosuria in gravid, and in 50 per cent. of all nursing women, but to prove moreover, that glucosuria, being in the direct ratio of milk secretion, in the lower animals as well as in the human species, would serve as a good test of the value of a nurse.

In the industrial arts, chemistry has led to the adoption of many new and economical processes; while in the cure of disease our treatment has become more and more precise and effective, since the separation and purifying of the vegetable alkaloids.

Improved articles of food for our hard-worked soldier and sailor—such as preserved fresh meats and fish, and compressed vegetables, condensed eggs, &c., &c.—are amongst the boons given us by chemistry.

If, during the present century, the advancement of medical science has increased the average duration of human life—and the truth of the statement cannot be denied—we may equally claim for surgery the merit of having borne a fair share in the good work. In endeavouring to select subjects in illustration, one feels embarrassed by the superabundance, rather than by the lack of material.

Hæmorrhage, once the surgeon's dread, has now lost its terrors; and when we but think of the painful means formerly in use, we are surprised that the modern improved treatment was not sooner adopted. The ligature of arteries, in amputations and other surgical wounds, naturally led to its use in aneurisms—in popliteal, and afterwards, as we became more assured, in other aneurisms. The first attempts to tie the common carotid, the subclavian, the external and internal iliacs, *may* be remembered by some present, and the endeavour to prolong life by tying the abdominal aorta, in Dr.

Monteiro's case, the patient dying on the tenth day of secondary hæmorrhage, *should* be in the recollection of the youngest of you. The first attempt to ligature the internal iliac was made in Jamaica, that of the abdominal aorta in Rio Janeiro—both within the tropics!!

Not satisfied with the triumphs he has obtained, the surgeon seeks further victories over disease and death, by the application of the ligature to the distal side of the tumor, when there may not be space on the proximal or heart side. Beyond this a further advance has been made, in the treatment of aneurism by pressure—an improvement originating in our own island. Conservative surgery, however, has more brilliant trophies to boast of: witness the resection of joints—of the elbow, shoulder, knee, and hip joints. Under conservative surgery may be classed plastic surgery, now so general. Adopted in Egypt and India in the fifteenth, and by Taliacotus in the sixteenth century, it was brought into notice in England by Lucas in 1803, and in 1814 by Carpus, whose success gave it a firm basis. Urethroplastic, first practised by Earle and Sir A. Cooper; and staphyloraphy, by Roux, in the case of my college friend, Professor Stevenson, of Montreal, were added to the triumphs of surgery. A good surgeon is no longer a man who is merely a *good cutter*; the desideratum being how much may be saved, not how much may be removed. I by no means object to legitimate operative surgery, and do not recommend for your adoption the course which Haller pursued, as he himself tells us in his biographical account, in his *Bibliotheca Chirurgica*. Eminent as he was as a dissector and consulting surgeon, and for seventeen years professor of surgery, he never ventured to operate on the living body—*"nervis ne nocerem verius."*

When I merely name lithotomy, tenotomy in cases of contracted joints, as well as in talipes, Symes' perineal section, and the reduction of dislocations by manipulatory movements, so long urged on the student by John Barclay of Edinburgh, what a field is opened to our view. War, in itself a monstrous, though at times perhaps a necessary evil, has enabled the navy and army surgeon to contribute much to our stock of surgical knowledge, and the opportunity so afforded has been turned to good account by the establishment of chairs of military surgery in London and Dublin—a boon conferred on the metropolis of Scotland soon after the battle of Camperdown, at the instance of John Bell. In its advance, surgery has been greatly assisted by the chemical and physiological reasoning of Simpson and others; for it may fairly be questioned if, without the aid of ether, or chloroform, or amylene, operative surgery would have made such progress. These and other anæsthetics, as cold, aconite, and belladonna, by lessening the nervous shock, have greatly diminished the mortality after capital operations.

You all know that the road to the Temple of

Knowledge is rugged and beset with difficulties—that the path is steep and toilsome; but though it be so, each step upward fully repays the fatigue; and the higher you ascend, you are the more raised above the clouds of prejudice, and obtain such views of the promised land of science as are forbidden to the low grovellers on the earth. Knowing, then, that such is the route to the promised land, how grateful should the student of these times be for the facilities afforded him by the labours of those who have preceded him. He has now to guide him onward the experience of many who were obliged, as it were without a pilot, to grope their way in doubt and uncertainty. We have, in the works of our predecessors, an amount of medical and surgical knowledge which the most lengthened life and extended practice could not of itself supply. On every subject in medicine, surgery, and their allied branches, we have special treatises or monographs, giving us the accumulated experience of all former authors; thus affording abundant sources from whence the student may drink deeply.

Rapid as has been the march of improvement in every walk of medical science, there yet remains much to be done, leaving ample ground for profitable labour. If we may judge of the future by the past, a large field is open to the student anxious for a knowledge of the truth. Will the physiologist tell us why the mere *malposition* of certain secreting glands should prevent the efficient performance of their normal duties? Why cryptorchidii, men as well as the lower animals, should be incapable of fecundating?—why no spermatozoa are discoverable by the microscope in their seminal fluid? Will the chemist pronounce for us whether the presence or absence of ozone in the atmosphere be the cause or the effect of certain epidemic diseases?—or can he declare whether this ozone be a distinct appreciable substance, or merely an allotropic condition of oxygen? Or will the chemist aid us in preventing the disease of the jaw-bones caused by the phosphoric acid in the manufacture of lucifer matches?

Never consider any discovery unimportant, however trifling it may seem to be. Let each new fact serve as the means of further advance. It may be, that though in appearance trifling, it will prove to be the one link wanting to complete the chain of evidence by which some important theorem shall be superseded. For instance, after Serotus had, in 1553, announced the pulmonary circulation, Cæsalpinus the swelling of the veins below the bandages in bleeding, and Fabricius, in 1574, the valves of the veins, our immortal Harvey, connecting these links with his own discoveries, at length, in 1628, gave to the world his account of the circulation of the blood. Harvey proceeded on the principle that every effect must have a cause, cause and effect being in indispensable union; that there could be no such thing as chance or accident; and that it was the duty of every philosopher or

lover of wisdom to search out carefully the rationale of every result. Thus acting, Leverrier and Adams foretold, not only that a disturbing cause acted on certain planets, but they pointed to the very spot in the boundless firmament where that element of disturbance should be found; and accordingly the telescope verified their inductions by the discovery of the planet Neptune. They were led to their convictions by reasoning on irregularities they had observed in the motions of Saturn and the Georgium Sidus.

In your pursuit of knowledge let not any unworthy motive sway you, but love knowledge for her own sake. That strange old author, Bernard, says—" *Qui scire volunt, eo fine tantum ut sciant, turpis curiositas est: qui scire volunt, ut sciuntur, turpis vanitas est; qui scire volunt, ut scientiam suam vendant, pro honore premio, &c., turpis questus est; qui scire volunt, ut adificent, charitas est; qui scire volunt, ut adificentur, prudentia est.*"

In conclusion, permit me, gentlemen, to thank you for the kind and able support you have on all occasions afforded me. To you I am indebted for my duties having been so easily performed. I have further to congratulate you on the increasing prosperity of the Belfast Clinico-Pathological Society; on the position it has obtained, and the high character it deservedly enjoys.

To say that the session now brought to a close has been prosperous to the Society and profitable to its members would but faintly express what I believe you all feel. The discussions have been truly practical, and that man must have been dull indeed who did not derive benefit from them. For myself I have to admit that week after week I found instruction in all that I saw and heard—a further proof of the adage, that it is never too late to learn.

With an increasing list of members—those members fully impressed with the advantages of our weekly conferences—your prospects are most promising; and I have no doubt that your progress will be continuous. *Eso perpetua!*

TRACHEOTOMY IN CROUP.

By Dr. C. T. ANJOU,

Of Wadstena.

The operation of tracheotomy, which is attracting so much attention at the present day, and which is deservedly looked upon as the only means by which the last stage of croup can be successfully combated, is no new operation. In the latter half of the preceding century, it was recommended by Home, who stated that he had recourse to it in threatened suffocation, the consequence of angina or croup; it soon, however, was allowed to fall into oblivion.

Bretonneau was the first (1835) who performed this operation with successful result in the last stage of croup, and he has, in a most valuable memoir, laid down rules to be observed in its performance, which are so accurate as to be still of value.

Trousseau, the pupil of Bretonneau, endeavoured to gain increased credit for the operation, by recording numerous cases in which it was successfully performed,

and by various improvements and modifications which he effected in the details of the operation, and by admirable treatises and statistical data, which he compiled.

Velpeau, Guersant, and other distinguished surgeons, enriched the statistics of tracheotomy by many successful cases, and caused an increased confidence in the operation by their endeavours to render it as simple and as easy as possible.

There are many children in Paris who have been tracheotomised for croup, and who owe their lives to these able surgeons. The statistics of cases in that city give nearly thirty per cent. of cures.

Although this result is far from unfavourable, yet the operation has found opponents, especially in England, where the cases in which it has been performed are not such as to induce imitation. Trousseau accounts for this by the supposition that the operation has been too long postponed, that the adventitious membrane has extended too far, while at the same time the patient's strength has been brought too low. Dr. West of London, is of the same opinion, although he seeks to make it appear probable that the disease presents different forms in the two countries. According to his opinion, in France the exudative process is chiefly limited to the upper part of the throat and trachea, while in England it extends more into the trachea and bronchial tubes; and moreover that complications of a severe character are more frequent. Although different epidemics of croup may unquestionably possess peculiarities of this nature, yet this improved hypothesis of West does not prove anything.

The cause of the untoward result appears to be partly that mentioned by Trousseau, and partly to arise from the addition of a less perfect and satisfactory mode of performing the operation.

In the *London Medical Times*, March, 1853, Dr. Smith records three cases of croup in which he operated, the result was fatal in all. He employed a piece of caoutchouc catheter, instead of the double canula, which we consider to be indispensable, and the result, therefore, is not such as to cause surprise.

In our own country the operation has also found gainsayers. One of our most distinguished writers, in a work on croup, thus expresses himself on the subject of tracheotomy:—"If the operation be looked upon as merely a palliative, then it is rational; but on this ground its general adoption cannot be recommended, for the advantages which it affords are too small. But when the idea is entertained of thus effecting a radical cure; if, as Michaelis, we would seek the means of extracting the false membrane from the trachea, or as Bretonneau, would destroy it by a solution of alum, or light application of caustic, then the whole proceeding must be held to be nothing else than an absolute absurdity." Experience, however, has shewn the reverse.

The child in the agony of suffocation, struggling with death, is often restored to life; and it is certain that we have frequently prolonged, by the operation, the life of a child whom we had looked upon as lost. Usually at the moment after the operation, a perfect respiration takes place, and the danger of suffocation is gone, at least for a time. Such aid is not to be despised. The pseudo-membranous exudations in the larynx and trachea can then be attacked and removed, and the inflammation may subside. Thus the seat of the disease is better brought under observation, and the physician has a fairer field for carrying out the measures which circumstances may demand. We consider it the duty of every physician, in the present state of the case, to communicate the result of his experience, with the view of in some measure lending strength to the facts adduced by the French physicians. On this ground, and because I am anxious to introduce the operation in this country where so many children fall victims to croup, I shall communicate those cases only in which tracheotomy was performed in the last stages of croup, and which I had the opportunity of observing in the great hospital for children in Stockholm.

The operation is in itself easy of performance; various difficulties may afterwards arise, which require the utmost circumspection and patience on the part of the physician. It stands to reason, that the earlier the operation is undertaken—or in other words, the more limited the extent of the false membrane, and the less the strength of the patient has been reduced—the greater is the prospect of a favourable issue.

As it is difficult to determine accurately the extent of the croupous exudation into the air-tubes, the operation must be determined on under all circumstances where the fits of suffocation increase in severity, and the approach of asphyxia becomes more imminent.

Guerant lays particular stress upon the fact of the symptoms of suffocation being constant or transitory; in the latter case, when the fits of suffocation return after long intervals, he advises that the operation should not be determined on too quickly, but that we should be on our guard, and only resort to it in the utmost need. Admitting the value which these directions may possess, I again repeat, that the earlier the operation is performed, the more favourable is the prognosis.

It has been a subject of discussion, whether we should resort to tracheotomy or laryngo-tracheotomy; and they who favour the latter, do so on the grounds of the air-tube being here more superficial, consequently more easily reached; that we have to do with fewer veins; and that we do not run the risk of wounding the innominate or the left common carotid, which sometimes takes an irregular course and crosses the windpipe.

Trousseau prefers tracheotomy; he performed the operation more than one hundred times without having encountered anomalies of the vessels, and when we go to work cautiously, according to his method, we run no danger of injuring a large vessel, either artery or vein. He further supports his views by referring to the probability of necrosis of the cartilage, to the greater danger of injurious consequences to the voice, from laryngo-tracheotomy, and finally, that in tracheotomy the windpipe is opened at a point to which the false membrane may not as yet have reached, or where it has been latest formed, and thus a prospect exists, by suitable treatment, of preventing the further extension of the evil.

With respect to anatomical details, it is to be remembered that in tracheotomy, the lower the point where the trachea is to be opened, the deeper it is; and that at the upper edge of the manubrium sterni, it is crossed by the left vena innominate, and that in croup the soft parts may be swollen and infiltrated with serum or air.

Dr. Anjou then describes the operation, and the instruments which are necessary, all which he states he has borrowed from one of the latest works of Trousseau on tracheotomy. He then says, the directions of Trousseau with regard to tying the veins I hold to be superfluous, if, indeed, they be not dangerous. On the one hand, the operation (which is frequently undertaken when it is of the last importance that not a moment of time should be lost) is thus delayed, and on the other a dangerous phlebitis may be occasioned.

If the operator has incautiously injured one of the larger thyroids or the brachio-cephalic vein, it may be necessary that it should be secured even to prevent danger to life, before the operation is finished.

The accidents which may arise during or after the operation, besides hæmorrhage, are next briefly alluded to.

If asphyxia should supervene, and respiration cease altogether, then the operation is to be brought to a close as quickly as possible, and the dilator introduced. Cold water should be sprinkled on the face and epigastrium, and pressure made alternately on the chest and abdomen; air may also be blown into the trachea, which is best done by introducing an elastic catheter into the canula, or if that be not at hand the operator may apply his mouth to the wound, and so bring about respiration. This must be done with caution, to avoid rupturing air-vesicles, and thus causing emphysema. If

blood flows into the windpipe, the patient must be laid with the head downwards. Sometimes at the close of the operation, syncope occurs, and at the moment when the respiration is free, and the congestion suddenly removed from the brain; in this case also the face should be sprinkled with cold water; some drops may also be allowed to trickle into the trachea. A feather may be introduced to excite the respiratory muscles, or a sponge at the end of a piece of whalebone, to separate the membrane, and facilitate the expulsion of the blood and mucus. In general the respiration becomes very tranquil after the operation; if this be not the case it is to be feared that the false membrane extends beyond the opening, or that fragments of blood coagula or membrane block up the passage; then there is no expedient except to keep the wound open by the dilator, and if possible remove the obstruction. Blood coagula or pieces of membrane are often expelled by dropping water into the trachea, by which cough is excited. Much more difficult is it to seize and draw out an adhering piece of membrane, which obstructs the trachea below the opening. Trousseau has, however, frequently succeeded with a small probang, a polypus forceps, &c., in removing false membranes, which were thus fixed in the bronchi. Patience and perseverance are in all such cases essentially necessary. When the breathing becomes difficult, and there is reason to suppose that the obstacle is in the artificial passage, then the inner tube is to be removed and cleaned; this should be done every three hours, or oftener if necessary.

When, as frequently occurs, the wound, after some days, becomes covered with false membrane, it must be touched daily with caustic. The application of a caustic solution, by means of injection, to the larynx and trachea, was at first had recourse to in all cases of tracheotomy, but is now given up; there may, however, be cases in which the cautious application of caustic will be necessary, an example of which is afforded by the fourth case. Care must be taken that the air of the sick-chamber is pure, and that the temperature is moderate. A rule of great importance is, that after five or six days all drinks should be avoided, and the patient restricted as much as possible to solids. As it is of the utmost importance that the canula should be removed early; if the disease progresses favourably after five or six days, the opening of the canula should now and then be closed with the finger, to compel the air to pass through the larynx. After repeated trials the artificial opening may be closed for a longer time; until at length we may venture to remove the tube, and unite the edges of the wound with adhesive plaster. This should be done morning and evening, and after some days the wound will be perfectly healed.

Dr. Anjou next gives a lengthened history of five cases, which we shall endeavour to condense.

1.—P. A. E., born 19th February, 1847, was brought into the hospital for children on the 20th of July, 1852. The nurse reported that the boy had cough for some days, but that for the last two days he was so hoarse he spoke with difficulty. There was nothing remarkable about his health in other respects; he had gone to school with the other children, but his appetite was not good. His condition on being brought into the ward was the following:—The face was swollen, and had an anxious expression; dyspnoea existed; the respiration was quickened, with prolonged inspiration; the murmur of inspiration was accompanied by a loud stridor: the veins of the neck were distended; the larynx was painful when moved. On auscultation of the chest, vesicular breathing was audible, with some catarrhal rales. Pulse rapid, full, and somewhat hard; tongue red at the edges, loaded at the centre; bowels regular, skin dry and hot. Half a grain of calomel was given every two hours, also a grain of sulphate of copper repeatedly; the glottis was touched with a ten-grain solution of nitrate of silver. For the two following days the condition of the

child was almost unaltered; on the third day, by following up the treatment, there was a marked amendment; the fever subsided; the respiration became less rapid and more easy. The improvement did not last long, for on the fourth day the symptoms became suddenly worse; fits of suffocation set in, which increased in severity until mid-day, when asphyxia seemed imminent. The face was cyanotic in the highest degree, and swollen; the look heavy and staring; the pulse had become rapid, small, and weak, and the body covered with a copious cold sweat.

Tracheotomy alone gave any hope of safety, and it was proceeded with at once. When the incision was made into the trachea, blood and mucus flowed out, and there issued also large and small fragments of membrane resembling chamois leather. After the operation was completed, and after the canula was introduced, the colour of the face assumed a lively red hue, on the respiration becoming easy; the expression of the countenance also was altered. Sleep came on, which, with the exception of the few minutes occupied in clearing the tube from mucus and secretion, lasted nearly a day and a half. A warm and general perspiration was induced. At two o'clock, p.m., the operation was completed, and at seven o'clock in the evening the child first awoke, the respiration accompanied with râles. The canula was withdrawn, and cleansed of blood mixed with mucus. At half-past ten o'clock the tube was again cleaned; the secretion was less bloody, but tenacious. The perspiration continued; the pulse was 126. At twelve o'clock the canula was again cleared; the pulse continued frequent. 25th.—At half-past one o'clock the tube was cleared of yellowish-red frothy mucus, but not so tenacious. After each time the canula was cleaned, the child fell asleep, and slept quietly. 26th.—The child passed a quiet night; pulse 120. 27th.—The night was passed quietly; less thirst; pulse 110. The condition of the patient steadily improved. On the tenth day the canula was removed; and after some days the opening was completely healed, and the boy recovered.

2.—Emilia Charlotte Anderson, born 1st July, 1851, admitted 24th July, 1854. At this time there prevailed much sickness in the hospital for children—an epidemic of measles, with its complications, croup, and bad form of stomatitis. The child had measles, and on the 24th croup set in; on the day previous symptoms of diphtheritis existed; in the course of the day the symptoms increased in severity, notwithstanding the measures employed; and in the evening a fit of suffocation came on, threatening to pass into asphyxia. At eleven o'clock at night the operation was performed, and all went on prosperously, until on opening the trachea a gush of arterial blood took place, which caused some confusion. The blood flowed into the air-passages, and excited cough and a paroxysm of suffocation. The child coughed up a quantity of frothy blood and mucus, and some small pieces of membrane. Fortunately the opening was narrow, so that force was necessary for the introduction of the canula, which had the effect of arresting the bleeding. After some blood and mucus were ejected through the canula, an easy and free respiration took place. For the first four days the child prospered; there was no marked fever; the character of the secretion was favourable; sleep and appetite were good; respiration free. During this period the patient was kept in the physician's apartments; on the fifth day the child was brought into the ward, in which were some children labouring under a bad form of stomatitis, and two with noma. The consequences of this imprudent step were not slow in appearing: the wound became the seat of gangrene; catarrh, fever, and finally colliquative diarrhoea set in, and on the eleventh day the child died.

The examination after death showed the following appearances:—Gangrene at the seat of the wound; emphysema of the lungs, which were in part collapsed and bloodless. The bronchi were filled with purulent secretion. In the larynx there was nothing remarkable; the

mucous membrane of the lower part was strongly injected, and, in the neighbourhood of the wound, covered with thin pus. There were two tablespoonfuls of serum in the pericardium.

3.—K. R. Sjöberg, born 24th March, 1844, was brought to the hospital, labouring under croup, on the 12th January, 1854. The disease had existed fourteen days. Tracheotomy, as affording the only chance, was undertaken. The child was to the last degree prostrated and cyanotic; death was imminent. After administering some restoratives, the operation was performed. The integuments were pale and flabby, and during the operation, which was quickly and easily performed, there was scarcely a drop of blood lost. On cutting into the trachea, the usual hissing noise was not heard; and on introducing the dilator and opening the wound, there was no relief to the respiration, which confirmed the opinion which had been formed, that owing to the long duration of the disease, the false membrane occupied the whole extent of the air-passages. All attempts to remove the false membrane were fruitless. The child died in two hours after the operation. The following were the pathological appearances observed on examination of the body:—The mucous membrane of the larynx was swollen, and covered with a grey false membrane, which almost completely closed the glottis. The whole trachea was lined with thick yellow croupous exudation, which had been torn by the operation and pressed down, thus rendering the entrance of air nearly impossible. The mucous membrane beneath the pseudo membrane was in a state of inflammation, and of a dark red colour. There was effusion of serum into both pleuræ. Tubercles were deposited on the right pleura, parietal and pulmonary. Both lungs were oedematous, and the lower parts of both congested; the right lung was tubercular. Throughout all the bronchi, even to the finest ramifications, the pseudo-membrane which had been found in the trachea could be traced; in the large bronchi, as in the trachea, it was cylindrical; but in the lungs it was solid, and filled the passage entirely. The other organs were not examined.

If such a state of things could have been anticipated as the *post-mortem* examination revealed—namely, that by the introduction of the canula the false membrane had been torn, and pressed down into the trachea—it would have been easy to have withdrawn the instrument, seized and extracted the false membrane. This shows the necessity of being prepared for all possible contingencies, and warns us not to give up too soon the hope of a favourable result.

4.—Th. F. Sundquist, born 14th April, 1850, was brought to the hospital on the 17th of March, labouring under croup. The boy had a catarrhal affection for some days before the croup appeared; he had been treated with emetic doses of sulphate of copper; Vin: Ipecac: had been given, and lunar caustic solution applied to the throat and rima glottidis. The symptoms of croup became more pressing from day to day. On the third day fits of suffocation set in, and the condition of the patient demanded that tracheotomy should be performed. On the 20th the operation was successfully performed. The catarrhal symptoms and fever continued. On the second day the secretion, which had been small in quantity, ceased altogether; the breathing became more laboured; and the wound was swelled, and covered with false membrane; fever came on, with a hot dry skin. Hydrarg: c. cretâ was administered, and the wound touched with caustic. No improvement manifested itself, and on the following night a fit of suffocation occurred. Fortunately I was at hand. The expression of the child was full of anxiety: the eyes protruded; the face was of a deep blue; the body was covered with cold sweat; he struggled for breath, and threw the arms about, &c., &c. The canula was withdrawn, and was found quite dry. A small probang, the sponge being filled with water, was introduced into the trachea through the swollen, gaping wound: the consequence was, that in addition to the mucus which came

as the sponge was withdrawn, masses of dry mucus, blood, and false membrane were forcibly ejected through the wound by convulsive paroxysms of coughing.

With a view of arresting the inflammatory process of the mucous membrane, and the disposition to the formation of false membrane, the trachea was touched with a solution of lapis infernalis (gr. x to the ounce of water). To support the strength a little sherry was given, and the mercury was continued. On the following day, another access of suffocation appeared; the same process was gone through, followed by relief. In the course of the day again a struggle with death. The secretion was thick, nearly dry, and mixed with blood. The vapour of hot water was inhaled, a large canula was introduced; nothing appeared to give relief. The fits came once or twice a day, requiring the measures above mentioned. The strength of the child obviously declined. The fever continued, with hot and dry skin. Camphor emulsion and wine were given alternately, a warm bath was directed, and towards night five grains of Dover's powder. At length there was an improvement; the fits of suffocation ceased, and all went on well. On the nineteenth day after the operation the canula was withdrawn, and after some days the wound healed. On the 15th of April the child was dismissed cured. Some hoarseness in speaking remained, but this ceased after a few weeks.

This case teaches how highly important it is to watch the patient after the operation, and shows what perseverance can accomplish. The child would have been lost if the physician was not at hand. The warm bath, camphor, opium, and, in a word, such remedies as act on the skin, are worthy of attention. Whether the repeated applications to the trachea were useful or prejudicial, I do not venture to determine.

5.—W. M. Uddman, born 17th April, 1850, was brought into hospital 2nd April, 1854. The child had bilateral pneumonia, with congestion of the brain. The child was progressing favourably, when, on the 17th of April, symptoms of croup supervened. On the 18th, asphyxia being imminent, tracheotomy was performed; with the exception of two fits of suffocation, which rendered it necessary to clear the tube, the child proceeded to recovery; and on the 16th the child was discharged cured.

The reflections which these cases give rise to, are left to the experienced reader. When the unfavourable hygienic state of the Great Hospital for Children at Stockholm at the period, is taken into consideration, the results arrived at are most encouraging.

If the case No. 2 be included, which would, in all probability, have terminated in recovery, if the patient had not been exposed to the bad miasmatic influences then prevailing in the hospital, of the five cases operated on, four were saved, or eighty per cent. It is not then a matter of surprise that I should have a predilection for tracheotomy in croup, when it has attained that stage in which all other means are inoperative; and that I wish to extend the practice in Sweden. The windpipe is opened without in general endangering life, as we not unfrequently observe in suicidal cases, and also when tracheotomy is performed in the adult for laryngitis, or with the view of removing foreign bodies. —*Hygiea and Journal für Kinderkrankheiten.*

TRANSACTIONS OF THE SWEDISH SOCIETY OF PHYSICIANS.

Session 1854-55.

Case of Chronic affection of the Brain. By *Hr. Malmsten and Retzius.*—Lieutenant J., aged about 50 years, who had for many years suffered from obstinate constipation, in the commencement of 1854, got pain, and a sensation of weight in the head, gradually increasing until spring, when he was attacked with symptoms of violent cerebral inflammation. He was then

attended by Dr. Klintberg, and got better. In the early part of summer he came to Stockholm, on account of his health, and then complained of obstinate constipation and severe headache. His articulation was slower than it had been in health, he had a staring look, and there was some weakness in the right extremities, causing the patient, in walking, to incline to the right. Attacks of severe cerebral congestion returned periodically, when there was extremely violent headache, more or less delirium, and very considerable contraction of the pupils. Such an attack usually terminated in five or six days, leaving the patient duller, and his speech more incoherent. Some organic disease of the head was suspected, but a difficulty was felt in defining its seat. The prognosis was unfavourable. The treatment consisted chiefly in the use of derivatives; iodide of potassium was not borne. The patient passed some weeks, during the latter part of the summer, at Bie, where a similar violent attack occurred; he subsequently returned to Stockholm, his disease becoming gradually more fully developed. During the last three months the torpor, incoherence of speech, and vacancy of expression of countenance increased, but no complete paralysis set in. The constipation was so obstinate, that no aperients had any effect. Spasms in the right arm and leg finally came on, and death supervened, after the patient had lain for some days in a comatose condition. On opening the cranium the convolutions of the brain were found to be flattened, and the blood-vessels highly congested. On the summit of the right hemisphere was a tumor one and a half inches long and one inch broad, elevating itself about a line and half above the normal softer brain. The ventricles were all filled, and somewhat distended with serous fluid. *Hr. Malmsten* added several observations upon the seat of the disease, and the symptoms during life; after which *Hr. A. Retzius*, to whom the examination of the brain had been intrusted, made the following report:—

In the region over the fissure of Sylvius, on the right side, the arachnoid and pia mater were thickened; the latter presented a considerable increase of vascularity. Within this was found a hard portion which, when it was examined, was ascertained to be a mass in part reddish-grey, and in part whitish-yellow, extending to a thickness of from three to five lines within the hemisphere, through what has been called the roof or lid of the fissure of Sylvius. From this the diseased mass extended to the remarkable cerebral ganglion, which *Burdach* has called the white part surrounding the lenticular nucleus (*corpora striata externa* of authors). On the surface of the ganglion a condition of softening existed, reaching, however, only a few lines inwards, with an extent of a little more than half a square inch. *Hr. R.* believed that the phenomena which had been most prominent during the patient's illness, proceeded from pressure and softening in this situation. On microscopic examination of the diseased mass, he had found that it consisted chiefly of fibrous elements, most abundant about the centre of the mass; and towards the surface more and more mixed with corrugated, and as it were hardened nuclei, somewhat larger than blood corpuscles, and rather yellowish in colour. In many places these lay crowded in small knots, as if they had been enclosed in cells whose walls were destroyed. A smaller number of so-called corpora amylacea, likewise corrugated and yellowish, also occurred here, with remnants of cerebral tubes, and cerebral cells of various sizes. This morbid mass had no defined boundary, no investing membrane, but was formed by a local deposition of fibrinous plasma from the blood-vessels passing into a state of induration. In some of the neighbouring portion of the brain a more recent acute inflammation of small extent had set in, causing softening and death.—p. 32.

Hr. Düben exhibited and described an anatomico-pathological preparation, obtained in the post-mortem examination of a person who had died of diabetes. All the changes usually found in cases of this disease were

present, most being referrible to the general emaciation and drying up of the body. There was also extensive tubercular destruction of both lungs. The preparation which was laid before the Society consisted of the stomach, with the œsophagus and left *nervus vagus*, from the pulmonary plexus downwards. About two inches above the cardia, close to the point where the branches of the vagus, separated above, are re-united, the nerve was surrounded by a calcareous concretion five lines in length and two and a half in its greatest breadth; this almost completely inclosed the nerve, and had compressed it in this situation; nevertheless the trunk of the nerve below the concretion appeared to be perfectly sound. About half an inch above this larger concretion, between the extended branches of the same nerve, was a smaller concretion about three inches in length, intimately uniting the branches by means of firm connective tissue. Without wishing to assert that diabetes always depends on some change in the vagus, Hr. Düben could not avoid directing attention to the agreement between the pathological condition just described and the result to which the most recent investigations on the subject of diabetes tend—namely, that the formation of sugar takes place entirely within and through the organs whose functions are determined by the vagus, and especially by the nerve of the left side. He believed that the formation of sugar, in this case, might wholly depend on the pressure of these concretions upon the nerve, and referred to Bernard's experiments. He ventured to lay the more stress upon the result of this examination, as it was the second example of the same kind. Thus he had, in a previous necroscopic examination of a diabetic individual, accidentally found a calcareous concretion on the left vagus. This did not surround the nerve, nor did it apparently stand in any particularly intimate relation to the latter. Hr. Düben said *apparently*, because if he had seen anything similar to what was found in the latter case, he should not have neglected to satisfy himself as to the true amount of connexion in the former one. As it was, he had only cursorily observed the situation of the concretion, dissected it out, and satisfied himself by ascertaining that it originated in a lymphatic gland. The same was probably also the case in the second instance.

Hr. Huss mentioned that the patient, a woman, from whom the preparation just exhibited was taken, had been under treatment in the hospital for the space of a year, until she was, last spring, at her own desire, dismissed improved. Towards autumn she came back, emaciated to the highest degree, and with a considerably increased amount of sugar in the urine. The type of disease was in other respects what is usual in diabetes, nor did any particularly prominent symptoms of an affection of the vagus exist; nevertheless, Hr. Huss considered it to be important to bear in mind the pathological changes just exhibited, in reference to future examinations, although their causal connexion with diabetes is not yet fully made out. Hr. Huss stated as a remarkable fact, that during last autumn not fewer than five persons had been in the hospital for diabetes; and he admitted that he had always been unfortunate in the medical treatment of this disease. He had, it was true, succeeded in diminishing for some months the amount of sugar and the quantity of urine, principally by means of creosote combined with opium, in progressive doses, and animal diet; but the disease had always returned. He therefore agreed with Rayer, and the French in general, who consider diabetes to be incurable by medicine. On the other hand, it is well known that our object may sometimes be gained in other modes; as for example, by the use of mineral waters, &c., &c. The speaker mentioned the case of a patient with fully developed saccharine diabetes, whom he sent, last spring, to Carlsbad, and who returned thence entirely free from sugar in the urine, and in other respects in good health, and who still, after the lapse of five months, continued without any trace of sugar in the urine. Still, the person from whom the preparation just exhibited was taken had, every

day for three months, drunk a jar of Carlsbad water, without any improvement; therefore, if in the present day some progress has been made in determining the nature of diabetes, we have not as yet surpassed our predecessors with respect to its treatment. Besides, it is uncertain whether their opinion as to the place where the sugar is formed—namely, that it is developed in the stomach—is not correct.

Hr. Malmsten observed, that cases of diabetes occur in which there are no symptoms calculated to lead to a suspicion of the existence of this disease. Thus he had, during last summer, a person under his care for ague, who, to all appearance, was in other respects quite well; but as the patient, during the intervals, complained of violent thirst, Hr. M. was led to examine his urine, and found that it contained a considerable quantity of sugar. The treatment consisted of alkalies, with the occasional use of quina. The thirst was diminished, but the urine continued, and still continues, highly saccharine. The man is in other respects perfectly well, observes a regulated diet, and purposes visiting Carlsbad in summer. Hr. Malmsten remarked that all such patients perspire freely, and that so long as this takes place, the formation of sugar appears to act less injuriously on the system.

In answer to a question by Hr. Grähs, whether, in the case detailed by Hr. Düben, the fourth ventricle or medulla oblongata presented any abnormality, Hr. Düben stated, that on examination they were ascertained to be perfectly sound.—*Ibid.* p. 36.

BIOGRAPHICAL NOTICE OF THE LATE CHEVALIER JEAN DE CARRO, M.D.

This distinguished man, who was the "first vaccinator on the Continent of Europe," died on March 12th, in Carlsbad, in Bohemia, where he had resided for the last thirty years. He was Doctor in Medicine of the Universities of Edinburgh, Vienna, and Prague.

Jean De Carro was born at Geneva, in 1770, and passed the first twenty years of his life in that town, receiving his education at the College. He came to England in 1790, with the view of studying medicine, which he had chosen as his profession; and, after residing two months at St. Osyth, in Essex, for the purpose of acquiring the English language, he repaired to Edinburgh towards the end of the year, and became a pupil in the university, where he attended the lectures of Black, Gregory, and other distinguished professors, who then gave celebrity to the institution. On June 24th, 1793, after an examination at the house of Professor Gregory, author of the *Conspectus Medicinæ Theoreticæ*, he received his degree of Doctor of Medicine. He subsequently proceeded to Vienna, where, having obtained his diploma, he married, and became attached to the British legation.

In 1799, having become acquainted with the discovery of vaccination, and being impressed with its value, he sent to England for some vaccine matter, with which he vaccinated his two sons. This is Dr. De Carro's own account; but Dr. Friedinger of Vienna, gives a somewhat different history. He says that on March 20th, 1799, Dr. De Carro received some lymph, on threads in a letter, from Dr. Pearson, the friend of Jenner. A month later—on April 29th—State-Councillor Dr. Ferro, then Commissioner of Health, vaccinated his own three children with the matter sent to Dr. De Carro; and on May 10th, one of Dr. De Carro's four children was vaccinated with matter taken from a child of Dr. Ferro: and subsequently Dr. De Carro's other children were vaccinated. These accounts slightly differ: but in both Dr. De Carro appears as the introducer of vaccination—a merit which Dr. Friedinger fully recognises.

Subsequently vaccination was introduced into Turkey chiefly by Dr. Scott and Dr. Auban, a French physician; and in 1802 Dr. Scott wrote to Dr. De Carro

that vaccination had commenced in Athens. Meanwhile Lord Elgin became most desirous to obtain this great blessing for India, and sought Dr. De Carro's assistance, through Sir A. Paget, the British Ambassador at Vienna.

Jenner appears to have failed in his repeated attempts to transmit vaccine matter to India, very probably, Dr. De Carro thought, from want of precaution in keeping it fluid. In his despair, he offered a reward from his own purse, of £1,000. Dr. De Carro succeeded in the attempt to transmit the vaccine matter in an efficient state, but from most honourable motives would not accept Jenner's offer of a reward. "He would have been happy to claim it from a sovereign or from a government, but never from a colleague." In compliance with the request of Lord Elgin, Dr. De Carro sent some fluid vaccine lymph to Bagdad. A child vaccinated there was sent, immediately after the operation, to Bassora; thence another child was sent on to Bombay; and thus vaccination was propagated through India, Ceylon, Persia, &c., until, in March, 1803, it had spread throughout our Asiatic possessions.

The priority of Dr. De Carro as the introducer of vaccination on the continent of Europe is attested by Jenner, in his *Continuations of Facts and Observations on the Variolæ Vaccinæ*, published in 1800.

The valuable services of Dr. De Carro soon began to meet with grateful recognition. Jenner sent him a silver snuff-box, on which was engraved "*Edward Jenner to Jean De Carro*." The East India Company voted him two hundred guineas for the purchase of a piece of plate; and on the occasion of his second marriage a present of two Cashmere shawls and three pieces of muslin was voted to him by the Honourable the Governor in Council at Bombay. The late Emperor Francis of Austria conferred hereditary knighthood on Dr. De Carro; the Hospitars of Wallachia and Moldavia, Alexander Morusi and Constantine Ypsilanti, many years ago, rewarded him by valuable presents; and Ludwig I., late King of Bavaria, conferred on his eldest daughter the honorary canonicate of the Royal Order of Ste. Anna—a decoration only conferred after proofs of nobility.

Dr. De Carro resided at Vienna during the greater part of the period from 1794 to 1826. In the latter year he settled at Carlsbad, in Bohemia, where he practised as a "spa-physician," during the remainder of his life. In 1843 the jubilee of the fiftieth year of his doctorate was celebrated with much honour.

In about 1800, Dr. De Carro published a treatise entitled *Observations et Experiences sur la Vaccination*, which seems to have been useful in the early diffusion of Jenner's discovery. In 1804 he wrote a *Histoire de la Vaccination en Turquie, en Grèce, et aux Indes Orientales*.

In 1851, when a very old man, he cordially gave his assistance in aid of the project of erecting a statue of Jenner. With reference to persons in Austria having declined to subscribe, on political grounds, Dr. De Carro observes, that he is "unable to understand what past, present, and future political systems may have in common with the Gloucester cows, who have been kind enough to supply us with an admirable preservative against the dreadful small-pox, or with God's mercy, who sent us the wonderful discoverer of this inestimable virtue."—*British Medical Journal*.

CORK MEDICAL AND SURGICAL SOCIETY.

At a meeting of the above Society, held on May 27th, the following officers were elected for the ensuing session:
President—Dr. R. Corbett.

Ex-Presidents—Dr. E. Townsend, Dr. Harvey, Dr. Finn.

Vice-President—Professor O'Connor.

Council—Dr. O'Leary, Dr. Lloyd, Dr. Armstrong.

Treasurer—Dr. Gregg.

Secretary—Dr. S. Henry Hobart.

BELFAST MEDICAL SOCIETY.

On Tuesday evening, June 9th, the members of the Belfast Medical Society celebrated their thirty-fourth anniversary, by dining together at Thompson's Rooms, Denegall-place, on which festive occasion there was a larger number than usual of the *élite* of the profession in attendance, thus showing the vigorous and healthy action of this long-established and influential society—one which has earned such a name for itself that distant associations, of a similar nature, have desired to be affiliated with it, in promoting the independence and increased usefulness of a body of men of all others of the utmost importance to the continued well-being and comfort of the human family. The President of the day was Dr. Beck; the Vice-President, Dr. Halliday; and the Stewards were Dr. Patterson, Dr. Stewart, and Dr. Dill.

DEATHS.

SIR JAMES EYRE, M.D.—We regret to state this esteemed physician died at the residence of a friend, at Clapham, on Friday morning, the 19th inst. He had attended the Queen's levee on the previous day, retired to bed in his usual health and spirits, and was found dead early in the morning. Sir J. Eyre was for many years in general practice at Hereford, and was knighted on the occasion of his presenting an address to the Queen from that town (of which he was then Mayor), on the birth of the Prince of Wales. He subsequently settled in London, and practised for some years in Brook-street. He published a work "On the Use of Oxide of Silver in Uterine Affections," and another entitled "The Stomach and its Difficulties." Both of these productions were of a semi-popular character, and had a large sale. Of late Sir James had partially retired from practice, and resided at Brompton. He was sixty-six years of age.

SIR ROBERT CAMSWELL, physician in ordinary to the King of Belgium, and formerly professor of pathological anatomy at University College, expired at his residence at Lacken, near Brusa, on the 16th inst., aged sixty-four.

We regret to state, that M. Tiénard, of world-wide chemical reputation, has just departed this life.

On the 17th instant, at St. Asule, whither he had gone for the benefit of his health, Thomas Berryman, M.D., of Alverton, Penzance, Cornwall, aged thirty-five M.D. Edin. 1842; M.E.C.S. Eng. and L.S.A. 1845.

May 28th, at Palermo, in Sicily, in his eightieth year, John Howell, M.D., Deputy Inspector-General of Military Hospitals.

COMMUNICATIONS have been received from Dr. Hobart (Cork); Dr. Barton; Sutherland and Knox; Professor Virchow; Dr. Shinkwin; Dr. Evans; Librarian, Royal Cork Institution; Dr. Williams (Cork), with enclosure; Dr. Barton.

TO ADVERTISERS.

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WHITWORTH AND HARDWICKE
HOSPITALS.

CLINICAL REPORTS OF MEDICAL CASES.

By Dr. M'DOWEL,
Physician to the Hospitals.

A few years ago I met with a case which at the time seemed to be an isolated and exceptional one. Its more remarkable features were the following:—

CASE I.

The patient (Donnelly) was a young woman about 27 years of age. On admission she was labouring under effusion into the left pleura; absorption was in progress, when suddenly delirium set in, followed by convulsions; then succeeded partial coma and paralysis of the left arm and of the left side of the face, with dilatation of the pupils. As the system was brought under the influence of mercury the paralysis became less marked, but retraction of the head became strongly developed. Dreading a fatal termination of the case, and unwilling that her death should occur in the hospital, her friends soon afterwards removed the patient, who only survived for a few days.

There was no examination of the body after death, but there can be little doubt from the symptoms, that to pleuritis with effusion there succeeded arachnitis, with inflammatory softening of the cerebrum to a greater or less extent.

The preceding case was brought to my recollection by one similar to it in many respects, which was lately under my observation, and which also terminated fatally. In the latter, however, the precise nature of the marked changes was not left to conjecture, but was accurately determined by examination *post mortem*.

Without meaning to imply that the two cases were identical, there seems to be a sufficient general resemblance to justify my connecting their histories in this manner.

VOL. IV.

CASE II.

Extensive Pleuritis with effusion.—Multiple Abscesses in the Brain.—Renal degeneration.

(Reported by Mr. WILLIAM KENNEDY.)

Bridget M'Dermott, aged 26, a healthy looking young woman, was admitted into the Hardwicke Hospital, May 6th, 1857. At this time, sub-acute pleurisy with effusion, on the left side, was diagnosed. The dulness was very extensive and well marked, and respiration in the affected side was almost extinct; and whilst there was little cough or expectoration, there existed considerable dyspnoea, with decubitus on the diseased side.

One important sign only was wanting, the absence of which might have made the diagnosis much more difficult, had the other evidences of effusion been less conclusive—the heart was not displaced, although the left side was enlarged. The costal wall had yielded to the pressure from within, whilst the mediastinum, which usually yields first, had not been displaced at all. From the history, the disease appeared to have existed for about a month. The patient was a good deal debilitated, weak, nervous, and anxious about herself. The period for any very active measures had passed by, and her condition besides did not call for such a line of treatment. She was directed to be freely dry cupped, a sinapism to be applied to the side, and calomel with James's powder, both in small doses, were directed to be given twice a day, whilst a mixture containing ammonia, camphor, and Hoffman's anodyne, was to be given at shorter intervals. Two or three days afterwards, the stomach becoming irritable, the medicine was discontinued; a blister was now applied to the epigastrium, and the saline effervescent mixture directed. For two days the vomiting continued. An enema of starch with twenty minims of laudanum, was ordered in addition. Though thus employing the remedies directed to relieve a gastritis, we were struck more than once with the discrepancy in the symptoms, for whilst the stomach was very irritable and the epigastrium tender, the tongue was moist, clean, and even pale, and never assumed any of the gastric characters.

On the 11th May, *the pulse had fallen to 50*; vomiting and hicough still continued; but with the pulse so slow we had no hesitation now in regarding the vomiting as sympathetic. For the first time, this morning the patient complained of pain in the back of the head and neck.

On the 12th her manner was greatly changed: her intelligence was no longer perfect; there was much stupor about her, and she raved much in a low and almost inaudible voice; the pulse was still 50 and very weak; the vomiting had ceased; urine and fæces were discharged involuntarily.

13th. This morning *cerebral breathing* was remarkably developed; she complained of pain in the head, which she was unable to localize; she sighed deeply, but was conscious and answered questions correctly though slowly. The pupils were much dilated. *Pulse had risen to 70*.

14th. Had a good deal of apparently natural sleep last night, but cried out loudly several times; is perfectly conscious; pupils dilated; respiration still rapid, 40 to 45; *pulse has risen to 100*, but is very weak and compressible.

From the time the head symptoms first appeared, the treatment was directed to combat cerebral inflammation. The head was shaved, the nape and occiput blistered, and mercurial innunction had recourse to; whilst diffusible stimulants were also necessary to combat the increasing asthenia.

On the 14th, the fourth day from the supervention of the symptoms denoting cerebral mischief, an apparent amendment had taken place, and at this period ptialism had been produced. No further change was observed, and without the occurrence of either convulsions, paralysis, or coma, death took place on the following morning.

Post-mortem examination.—Head.—The membranes and the exterior of the encephalon were perfectly healthy. On cutting into the substance of the brain, an immense number of abscesses were discovered; these were of various sizes, from what would contain a very small pea, to the size of a large walnut. Of the larger there were from six to eight; of the smaller, perhaps, fifty or sixty. In fact, the brain was so universally pervaded with them, that it would have been impossible to have determined their number with accuracy, and it is likely that their number is here understated. They all had certain characters in common; all were of a circular form, and contained green-coloured pus, of the thickest consistence which that fluid ever assumes, whilst the cerebral tissue around them was perfectly natural as to colour and consistence. The largest deposits, two or three in number, were in the cerebellum. The grey matter, and the central masses of nervous matter (ganglions), were perfectly healthy. In all instances the purulent collections were situated in the white fibrous tissue.

Thorax.—There was very copious effusion of sero-purulent matter into the left pleura. A li-

mited band of adhesion, which was obviously of old date, kept the pericardium united closely to the adjacent parietes, and thus accounted for the peculiarity of *non-displacement* of the heart, coinciding with extensive effusion into the left pleura. The heart was healthy.

Abdomen.—The abdominal viscera were healthy, with the exception of the kidneys, which were equally and similarly diseased. A microscopic examination, made by my friend, Dr. Robert Macdonnell, confirmed the opinion which the general appearance of the kidneys had led us to expect, viz., that they were in a state of "fatty degeneration." In the left kidney, a dark-coloured calculus (probably oxalate of lime), obstructed the upper extremity of the ureter.

The case now detailed is a remarkable example of intra-cranial suppuration. To regard it as an instance of suppuration, depending on cerebritis, would be erroneous. The symptoms and the morbid appearances are not reconcilable with each other, unless we regard the cerebral suppuration in this instance, as the result of pyæmia. In the majority of cases, suppuration of the brain is the result of some form of encephalitis, and hence some symptoms denoting cerebral irritation, as pain, delirium, rigors, convulsions, &c., usually precede those which indicate the formation of matter; but in this instance, with the exception of vomiting (the most constant of the premonitory signs of cerebral affection), the earliest symptoms were those of pressure. Pus was here poured out insidiously into a *healthy* brain, and hence remarkable slowness of the pulse was one of the first symptoms observed. According to this view we have here an example of "a disease in a part, yet not of a part;" suppuration in the brain, but not suppuration or suppurative softening of the brain.

There is, I am aware, nothing new in the record of a case in which extensive suppuration of the brain has occurred, with few symptoms to denote any serious affection until shortly before the fatal termination. As a general rule suppuration of the brain is an insidious disease, but the diversity of symptoms may, perhaps, in some instances, be explained by a reference to the cause of the suppuration. Where inflammation of the cerebral substance has preceded suppuration, symptoms, more or less strongly developed, will precede the signs of pressure; but on the other hand, when pus is deposited, owing to a morbid condition of the blood, we can understand how the earliest symptoms of cerebral affection may be those which indicate pressure on the nervous substance.

The co-existence of degeneration of the kidneys, in this instance, is deserving of serious attention. I believe there is a more intimate connexion between pyæmia and chronic renal disease, than is generally recognised. I still find that fatal cases of suppurative pneumonia are *only* met with where renal degeneration had previously existed; and I

could adduce a great many cases in addition to one above detailed, in support of the opinion which may be thus stated in general terms, that low forms of inflammation ("unhealthy inflammations"), diffused suppurative inflammations ("diffuse inflammations"), and pyæmia generally, are of very rare occurrence, except in those persons whose blood is depraved in consequence of defective renal depuration.

CLINICAL REPORTS OF SURGICAL CASES IN STEEVENS' HOSPITAL.

By SAMUEL A. CUSACK, F.R.C.S.,

Resident Surgeon, and Lecturer on Anatomy and Physiology in the Medical School of the Hospital.

Case of Extravasation of Blood from Rupture of the Middle Meningeal Artery.

John Ramsay, aged 16, was admitted into Steevens' Hospital, on Monday, the 22nd of June, 1857, under the care of Mr. Colles. On the Saturday before admission, he had been knocked down twice while fighting with another boy; on the last occasion the back of his head struck against a wall, and he remained on the ground, unable to move, for about an hour, during which time he vomited, and complained several times of pain in the head; after this he walked home, with the assistance of another boy, and was put to bed. He had a restless night, with much pain in the head at times.

Next morning (June 21), while being offered some food, he complained of a sudden pain in the head, and became quite insensible. Medical assistance having been procured, his head was shaved, fourteen leeches applied, and the bowels were moved by an enema. He appears to have remained much in the same state until Monday, the 22nd, when he was brought into the hospital, at 11 a.m. On admission he lay on his back, apparently insensible, but when told in a loud voice to put out his tongue, would do so. His face was pallid; the pupils widely dilated; respiration tranquil, and free from stertor; pulse 100, and feeble; tongue white and creamy; his left side was paralysed; he was constantly tossing the right leg and arm about, and winced when they were pinched; he passed his urine and fæces involuntarily. The head, which had been shaved, was carefully examined, but no injury, or even bruise, could be discovered. He was ordered three grains of calomel every third hour, and a blister to the top of the head.

June 23.—He seems rather more sensible than yesterday, and takes plenty of beef-tea out of the drinking-cup.

June 24.—Much in the same state; slight mercurial fætor.

June 25.—The pulse rose to 120 during the

night; respiration remarkably free and tranquil. He never speaks, but puts out the tongue when desired. Towards evening the pulse diminished in frequency, and became more feeble. He was ordered wine \mathfrak{z} viii.

June 26.—Much in the same state as yesterday until about 4 p.m., when he died quite suddenly, in a state of syncope.

Post-mortem examination, June 27, 6 a.m.—Scalp over occiput and right temporo-parietal articulation of a dark colour. Diploë congested in the same situation. On removing the calvarium the dura mater was found to be separated from the whole of the squamous surface of the temporal bone, and a considerable portion of the adjacent surfaces of the parietal, frontal, and sphenoid bones, by a large clot of blood, which had escaped from a rupture of the middle meningeal artery at the junction of the sphenoid and parietal bones. The clot was oval in shape, about four inches in diameter, and one inch thick. The corresponding surface of the middle lobe of the brain was pale and flattened by the pressure of the dura mater, but regained its natural shape after twenty-four hours maceration in spirits and water. The clot of blood remained firmly adherent to the outer surface of the dura mater, even when held under a stream of water.

Fracture through the body of the Fourth Cervical Vertebra.

Michael Mara, aged 50, was admitted into Steevens' Hospital on the 20th of April, 1857, under the care of Mr. Wilmot. At two p.m. on that day, he was thrown from a cart on which he was standing, by the horse suddenly moving on. He fell on his back, his shoulders first coming to the ground, and he thinks his head bent forwards. He felt a good deal of pain in the neck, and attempted to rise from the ground, but was unable to use his limbs. He was carried to the hospital at once, when it was found that all his limbs were paralysed, the arms partially and the legs completely. He could just lift the left arm from the bed, but could not move the fore-arm or fingers. He had perfect sensation in all his limbs; his respiration was altogether from the diaphragm; his pulse was natural; he looked drowsy; his head was stiff and bent forwards; any attempt at motion gave him pain. From the rigid state of his neck it was difficult to say whether there was any irregularity in the spinous processes or not. He was placed in bed, the head supported by pillows, and ordered pills of calomel and opium every three hours. During the night his fæces passed involuntarily, and he required the use of a catheter.

April 21.—Much the same; pulse 85. Ordered cupping to the back of the neck.

April 22.—Rather more drowsy than yesterday; pulse 108; breathing frequent and oppressed. The opium was omitted. A sinapism was applied

to the chest. At 4 p.m. he died comatose; by this time his lungs had become much congested, and the mouth filled with frothy mucus.

Post-mortem examination, April 28, 6 a.m.—Posterior cervical region gorged with blood; preternatural mobility of the head; blood very fluid and black; a transverse fracture extended through the body of the fourth cervical vertebra; the injury was confined to the body of the vertebra, and no laceration of the ligaments could be detected. There was a clot of blood about the size of a threepenny on the anterior surface of the theca; there was also a minute clot in the centre of the right column, and the medullary substance was somewhat softened opposite the seat of injury. On passing the finger over the fracture, after the theca was removed, a thin, sharp, projecting spicula could be felt, but otherwise there was no displacement. The lungs and right side of the heart were congested; the brain was healthy.

Concussion of the Spine, followed by Cerebro-spinal Arachnitis.

Catherine Bornan, æt. 19, was admitted under the care of Dr. Croker, on the 20th of November, 1856. She states that four days ago she began to be affected with a dull, aching pain in the lumbar region, which she attributed to a fall from a swing a few days before. On admission it was observed that the pain in the back prevented her from standing upright, and that her face was livid and purple from obstructed respiration, which was chiefly diaphragmatic. No bruise or indication of injury could be discovered in the situation where she had received the hurt; there was no pyrexia, and it was thought that the disease might possibly be hysteria. Ordered a purgative enema, and a warm bath. There was little change in the symptoms or treatment until the 24th, when she had some difficulty in passing water; this was relieved by the warm bath; but on the evening of the 25th, the retention was complete, and from that time she required the use of the catheter. The urine drawn off was very ammoniacal and fœtid. About this time she began to complain of acute pain in the head, with some debility of the lower extremities, though she had hitherto been able to walk about the ward. Calomel and opium was ordered every third hour, and leeches were applied to the lumbar region.

On the 27th it was observed that she had lost all sensation in the lower extremities. Additional leeches ordered to the back.

28th.—During last night she had an attack of rather violent delirium, during which she walked about the ward; her manner remained incoherent; her face was flushed, and she had strabismus of the left eye.

29th.—She is rather more feeble, and the left eye-lid hangs; the mouth is slightly touched with mercury. Towards evening the paralysis began to affect the muscles of respiration; the lungs soon

became congested; and she died comatose during the night.

Post-mortem examination, Nov. 30th, 6 a.m.—The posterior and lateral surface of the spinal cord covered with patches of red lymph; the substance of the cord red and soft, just at its termination in the cauda equina. The ventricles of the brain and sub-arachnoid space contained a good deal of turbid serum; there were also a few patches of lymph on the posterior surface of the hemispheres.

The cases here detailed are interesting rather as illustrating the pathology and functions of the cerebro-spinal system, than as throwing any light on the diagnosis or treatment of its disease. The first case would appear to be one of those in which there is at first a small flow of blood from the ruptured artery, not sufficient to cause any great derangement of the cerebral functions, but subsequently, as reaction sets in, causing more extensive compression of the brain by a further extravasation of blood. It was remarkable for the freedom of respiration and absence of stertor throughout, a condition usually present when the injury is at the lateral surface of the brain; and which, combined with the fact of the paralysis being confined to one side of the body, (even in the absence of any external bruise or injury,) might seem to have afforded a sufficient indication that the trephine could have been used with some prospect of success. The *post-mortem examination* however, showed that even if a portion of the clotted blood had been removed the remainder of it was so firmly adherent to the dura mater, and extended so far into the middle fossa of the shell, that its complete removal could not have been effected, and also confirmed the opinion at present entertained, that lateral compression of the brain tends to produce syncope and muscular debility, rather than impairment of the respiratory powers.

The second case is interesting merely for its pathological character. Nothing could have been done to relieve the pressure of the broken spinal cord, and time was not left for its absorption.

In the third case it is difficult to say whether the arachnitis was idiopathic or the result of the previous concussion. The symptoms were at first obscure, owing to the absence of convulsions, or well-marked symptoms. The disease appears to have originated in the softened spot at the commencement of the cauda equina, and to have extended from thence along the posterior and lateral surface of the cord to the brain. It was remarkable that while sensation in the lower extremities was lost early in the disease, the power of motion remained to the last. It is difficult to conceive that she could have walked about the ward the night before she died, and after the limbs had become feeble, and sensation had been lost; possibly there may have been a temporary return of sensation, and in such cases it is reasonable to suppose that locomotion may be the result of reflex

action, combined with imperfect sensation. The *post-mortem* examination was also interesting, as confirming the theory already received, that lesions of the posterior and cervical portions of the spinal cord are accompanied by impairment chiefly of the powers of sensation.

CASE OF CARDIAC DISEASE, IN WHICH THE SYMPTOMS WERE INTERMITTENT.

INFLAMMATORY THICKENING OF TRICUSPID VALVES.

By J. K. BARTON, M.B.

Michael M'Donough, a strumous-looking boy, 18 years of age, was admitted into the hospital of the North Dublin Union, under Dr. Kirkpatrick's care, upon the 2nd of February, 1857, for a chronic abscess in the upper part of the left thigh. Upon the 16th of February the nurse reported that M'Donough was very ill since the night before, with difficulty of breathing. We found him sitting propped up in bed, his countenance expressive of distress and anxiety; his lips blueish; the superficial veins of the neck remarkably swollen, and pulsating with every beat of the heart, which was acting with extraordinary rapidity, being 180 in the minute. He complained of great dyspnoea, and a sense of weight and pain in the cardiac region, where he said he was sure his disease lay. Auscultation did not give us much information, on account of the rapidity of the heart's action, which made the sounds merge into one another, forming a dull, continuous, jumbling sound, in which it was impossible to say whether there was any abnormal sound or not. We learned from him that he had suffered from rheumatism about a year before, when his heart was affected, and that ever since he had been subject to attacks such as he now laboured under; he had had them five or six times; they had gone off in a day or two; he did not think they had ever been so bad before. Dr. Kirkpatrick came to the conclusion that there was some temporary obstruction to the heart's action; and as the skin was cold and the pulse very feeble, he was ordered an ether mixture; wine to be cautiously given, with water, every hour; and a mustard poultice over the heart; the bowels to be freed by a fetid enema. Next day he was much better, and the day after as well as before this attack. His pulse now counted 80, was freer, and regular; and accompanying the first sound of the heart was a loud bruit, most distinct at the apex. That there was narrowing of the mitral orifice, probably the result of former endocarditis, seemed certain; but to what was the obstruction to the circulation through the heart, which had existed to such a great degree two days before, and had now entirely disappeared, to be referred? The pulsation so visible in all the veins of the neck pointed to an imperfect action of the tricuspid valve; but now the right

side of the heart was acting regularly, and in a perfectly healthy manner.

Upon the 27th of February he felt unwell, went to bed early, and shortly after was suddenly seized with headache, and violent action of the heart, and dyspnoea—in fact, the same train of symptoms from which he had suffered on a former occasion. The pulse was, as well as could be counted, nearly 200, weak and fluttering. The same treatment was resorted to, but he was more liberally supplied with stimulants, the bowels, which were confined, being relieved by enemata. Upon the 3rd of March he was all right again, the attack having terminated gradually the day before, lasting therefore three days. During the months of March and April he had frequent returns of these attacks, varying in severity and duration, sometimes lasting only a few hours, sometimes two or three days. The intervals, too, between the attacks varied: sometimes a fortnight would elapse without any, sometimes only a few days. The stimulants with which he was supplied seemed to support him, and keep up the action of the heart until the attack passed off; but the most marked and immediate relief followed, upon several occasions, from free vomiting, which came on spontaneously; but when, having observed this, an emetic of carbonate of ammonia and mustard was administered the next time the attack came on, no relief followed, although vomiting was produced. Towards the close of April it became evident that the system was giving way before these repeated assaults; the attacks continued for a longer time, and the relief was not so complete at their termination as formerly; his feet became oedematous, and an attack which came on upon the 10th of May proved to be his last. No remedies were now more than of temporary avail in aiding the struggling heart, and upon the evening of the 13th he died.

A *post-mortem* examination was made upon the following day. The face was purple and swollen, and the lower extremities oedematous. The pericardium being laid open, the heart was seen to be hypertrophied, marked externally with several large white spots, particularly near its base, over the auricles; it felt remarkably hard and firm when handled, and was more globular than usual, being evidently distended by its contents. The right side was filled with a firm yellow coagulum, which extended through the auriculo-ventricular opening, from one cavity to the other, entirely filling up both the auricle and ventricle, and the orifice between them. It extended a short way into each vein, and also through the pulmonary artery into the lungs. There were no red corpuscles in this clot; it seemed entirely composed of fibrine and serum, which last flowed from it in quantities when it was pressed; but it was very tough, requiring considerable force to pull it into pieces. The tricuspid valves were white and thickened, the cordæ tendineæ being markedly so, but the orifice was not contracted. The muscular wall of both auricle

and ventricle was much harder than natural, and showed, when cut, a yellowish kind of deposit through it. The left cavities were also filled by a coagulum, but it was neither as tough nor as colourless as that upon the right side. The mitral valve was greatly thickened and puckered, and its orifice would only admit the tip of two fingers. The lining membrane of the ventricle was white and thickened, and so were the aortic valves.

The apices of the lungs alone crepitated under pressure; lower down they presented evidences of repeated hæmorrhage having taken place into their substance. Extensive adhesions of the pleura existed upon the right side. The liver was fully twice its natural size, extending entirely across the epigastrium into the left hypochondrium, the result of engorgement from obstruction in the inferior cava. The other organs were healthy.

Here were the evidences of a true carditis—fibrinous deposits being found in the substance of the heart, and on its serous covering and lining; the latter giving rise to thickening of the tricuspid valves, and thickening and contraction of the mitral. As an explanation of the very remarkable symptoms which existed in this case, I would suggest, that the heart being enfeebled by the injury its tissue had undergone, favoured, by its weak action, the formation of coagula in its cavities; and these, the blood being overloaded with fibrine, readily deposited, probably first in the substance of the tricuspid valve, which, from the thickening it and the cordæ tendinæ attached to it had undergone, could not have perfectly closed the orifice between the auricle and ventricle. A piece of fibrine caught in this way in the orifice, would account for the symptoms of obstruction to the circulation through the right side of the heart; while its being washed away in the torrent of the circulation would explain the remission of those symptoms until it again formed.

REMARKS ON INJURY OF THE PRONATOR TERES MUSCLE,

ATTENDED WITH CREPITUS.

By JOHN WILLIAMS, M.D.,

Surgeon to the Cork Eye Dispensary.

It is invariably in accordance with the degree of clearness or obscurity by which the physical signs and symptoms—not only of injuries but of diseases also—are attended, that differential diagnosis in some cases, and diagnosis itself in others, becomes a matter of simplicity or of extreme difficulty. Hence it is obvious—as successful treatment is so dependent on a precise diagnosis—how important it becomes in describing an injury or disease that has before been but imperfectly known, first, to carefully abstract those signs and symptoms which may be regarded as characteristic, from those which are common to other

affections also; and secondly, to again review each abstract symptom, ere it be admitted into the pathognomonic group.

The injury I am about to describe—and as far as I am aware no description of it has as yet been given—is one of some consequence. It is a simple lesion of soft parts, therefore its diagnosis from fracture of the radius is of great importance, as it may involve the credit of the surgeon; and instances are not wanting where such a mistake has occurred. Dr. Thompson, in the *HOSPITAL GAZETTE* for June 16th, has recorded three interesting cases of inflammation in the sheaths of tendons attended with *frottement*; and it is not improbable that those cases, which but lately occurred in his practice, and which “but for the accompanying *frottement*, would have been obscure to him,” were examples of the injury in question. Of the cases that I have seen I shall give the following one in illustration.

Catherine Duggan, a washerwoman, applied for advice in June, 1856, complaining of inability to use her right hand. While in the act of wringing clothes the day before, she suddenly experienced a sharp pain in the centre of the right forearm, which speedily became powerless. She came to me supporting the affected arm with the other, and complaining much of the pain. On examination, the forearm was hot and tense to the touch, and at its centre a swelling was seen, which formed a *hard and oblique ridge on its anterior, outer, and posterior aspect*; pressure on any part of the arm, *save on this elevated ridge*, did not cause pain; but the most remarkable sign was a distinct *crepitus* or *creaking sound*, which was not only experienced when the hand of the surgeon was placed on the swelling, and the forearm *pronated* or *supinated*, but it could also be plainly *heard*. Although the patient complained that there was no power in the limb, she could, with reluctance however, raise it from its support. The treatment I adopted was the placing of a single splint along the anterior aspect of the forearm; a few days rest, and afterwards camphorated oil applied to the part, enabled her to resume her work. Within the past week I had an opportunity of hearing from her; she states there is “a hard swelling where it originally was, and that much washing injures her arm very much.” From the frequency with which this injury is to be seen in women employed in washing, it appears to be almost peculiar to them; but I have seen it in others.

The symptoms common to this injury and fracture are, loss of power in the limb, pain on pressure, referred to a particular point, and crepitus: the diagnosis, however, is rendered easy, by attending to the following points. The patient, although unwilling, *can* raise the forearm without assistance, and flex and extend it; *pronation* or *supination* alone causes pain, which in general is very acute, and those two motions are also the only ones which cause the crepitus, which is more

a dry creaking, as Dr. Thompson remarks, like that of a new shoe, than that caused by the ends of a broken bone; also if the elbow be fixed, and the carpal end of the radius forcibly moved, no pain is given to the patient, or any idea entertained that the continuity of the bone is not intact; but the constant sign of this injury is the occurrence of the *oblique elevated ridge* at the outer and anterior aspect of the centre of the forearm, which exactly marks the course of the pronator teres muscle, and which muscle, when we come to investigate the cause of the injury, will be found, in my opinion, the only one, or at least the principal of the pronators, that suffers.

In some trades, and in washerwomen when *wringing* clothes, great resistance is constantly offered to the pronators of the forearm, and when the injury occurs, sudden pain is experienced, which is referred by the patient to the exact point where the pronator teres winds round the outer margin of the radius, to its insertion on the posterior surface of that bone. Of the exact lesion that occurs I am not of course aware; but I presume some of the fibres of the muscle, which, as it winds round the bone, are tendinous, are ruptured. The superficial course of the muscle also aids us in recognising it as the seat of the injury.

With respect to treatment I would recommend a single splint to be placed along the anterior aspect of the forearm; if there be much inflammation a few leeches may be used, and lotions as may be agreeable to the patient; afterwards iodine, or friction with camphorated oil. I have never seen recovery tardy; but from the fact that the affection is apt to recur, I think it probable *rupture* of few or more of the muscular fibres actually takes place, when the injury is first received.

PARTIAL PARALYSIS OF THE EXTREMITIES CAUSED BY THE CONTINUED USE OF SNUFF CONTAINING LEAD.

By Dr. MORITZ MEYER, of Berlin.

Archiv für pathologische Anatomie und Physiologie und für Klinische Medicin.

Since the publication of Trochin's work, and the essays of our distinguished countryman, Sir George Baker, nearly a century has elapsed, and during this period numerous have been the contributions to our knowledge, and great has been the interest excited on the subject of the contamination of the system by lead. Of late much light has been thrown on the subject abroad by Merat, Tanquerel, and more recently by Melsens, with whose memoir, originally published in the *Annales de Chimie et de Physique*, the English reader is familiar through the translation in the *British and Foreign Review*, by Dr William Budd.

In our country Professor Christison and Dr. Burton have done much in the same direction.

In a therapeutic point of view we consider the

memoir of Melsens on the treatment of metallic poisoning by Iodide of Potassium as one of the most valuable additions to practical medicine which has been made for some time. In expressing this opinion we speak from rather an extended experience of the influence of the iodide in the elimination of lead from the system, having since the publication referred to treated many cases of the different forms of saturnine poisoning after the manner recommended by Melsens, and with results which have led us to recommend his plan in the strongest terms to the pupils who have watched its effects in the wards of the hospital.

We were well acquainted with the various ways by which lead finds admission into the human body, and the symptoms which follow as a necessary consequence of the contamination of the system; but we confess we were not prepared for the fact which Dr. Meyer has established, viz., that snuff impregnated with lead is not an unfrequent cause of saturnine poisoning.

In the year 1854 Dr. M. published a case of lead paralysis, caused by the long continued use of snuff containing lead. In this case he employed electricity both as a diagnostic and a therapeutic means.

The subject of the disease was a furrier, aged 38; he had experienced weakness of both hands and inability to move them well; but for three months before he was seen by Dr. M. he had completely lost the power of extending the hands. He was otherwise healthy, but his complexion was of a sallow hue. The paralytic symptoms were not preceded by any abnormal sensations except slight dragging pains of both shoulders. A powerful electric stream directed along the course of the extensors did not throw them into action. The electro-muscular sensibility of the paralysed parts was diminished, so much so that a strong current was scarcely perceived.

The treatment employed in this case, which was clearly one of lead paralysis, consisted in the protracted use of electricity, sulphureous baths, and saline purgatives. The recovery was slow, but the cure was complete. The use of the snuff was abandoned as soon as the cause of the disease was discovered.

The snuff was (Pariser No. 2, manufactured by Bernard of Offenbach) packed in lead, and the patient, who purchased it by the pound, preserved it in the leaden envelope.

As far as Dr. Meyer knows, no case resembling this has been since communicated, and having since encountered three others he considers it his duty to make them known, believing that chronic lead poisoning is not unfrequently produced in the manner alluded to.

The second case was a man aged 43, who, since 1845, had been in the habit of taking snuff packed in lead (Pariser No. 3). After having suffered for months from painful distention of the abdomen, especially in the umbilical region, he was seized in

December, 1851, with a severe attack of colic and constipation, which lasted for six days. The like symptoms returned; the colour of the skin assumed a yellowish tinge and great difficulty of digestion existed. In 1852 and 1853 the gentleman was sent to Carlsbad, but soon after his return in October he was again attacked by colic—again in the following February, and this attack was accompanied with paralysis of the first two, and afterwards of the other fingers of the right hand, and finally of both arms. He was first seen by Dr. Meyer in the July of 1855; he was then emaciated, anæmic, and of a yellowish waxy hue. The gums had receded from the upper teeth. The muscles of the arm were wasted. Extension was impossible. The electro-muscular contractility and sensibility of the extensors remarkably diminished. After the employment of sulphureous baths, saline purgatives, and the daily use of electricity for six weeks, there was a manifest improvement. The patient was able to raise his arm from the shoulder-joint, but extension of the wrist was still impossible. His appearance and his spirits had also undergone a favourable change. The power of the muscles gradually returned and he was able to write. In the month of May, 1856, recovery was complete.

The third case was that of an advocate, in whom the paralysis was far more advanced than in the others. He was born in 1814, and at the age of 27 he began to take snuff abundantly. According to his own statement, he used "Pariser No. 3," uninterruptedly, which he preserved in the leaden envelope for the purpose of keeping it moist. After five years (1846) gastric symptoms appeared with fever, distension of the abdomen, pain with colic, and obstinate constipation. He also suffered from loss of appetite and want of sleep.

The skin and the sclerotic gradually assumed a yellowish colour, the hands began to tremble, and in the year 1851 this increased so much that he could not write.

In the autumn of 1852, after an attack of colic of great severity, both upper extremities became completely paralysed.

In the year 1854, after another severe attack, the lower extremities also were affected in the like manner, having previously been affected with spasms. The Marienbad waters, &c., had the effect of removing the paralysis of the lower extremities, and the following year having learned the injurious effect of the snuff he ceased to use it. Nevertheless, in July, 1856, he presented a miserable appearance; the muscles of the arm were lax; the fore-arm like that of a skeleton; extension of the wrists and fingers impossible, the latter could be separated only very slightly from the palms of the hands. The face presented the aspect of saturnine poisoning. The electro-muscular sensibility was diminished in the extensors.

In the course of six weeks, during which the

paralysed muscles were daily electrified, the patient was able to extend the wrist-joints, especially the right, and was able to separate the fingers from the palm of the hand to the extent of three or four inches; the reaction of the paralysed muscles had materially improved. At this period the patient passed from under Dr. Meyer's observation.

The fourth case was presented in the person of a gentleman formerly himself a practising physician, Dr. Kaehler, aged 45, who for the first time suffered six years since from frequent pains in the recti muscles, with painful distention of the abdomen, and a sensation in the left hand like the creeping of ants. This patient presented all the symptoms noted in the former cases in a high degree, but the constipation was more obstinate than in any of the other cases. He derived such benefit from iron baths and from the use of the Driburg waters, that he expected a lasting cure by these means, but the improvement was only temporary—the symptoms returned. However, on giving up the use of the snuff and having recourse to sulphureous baths and the Bitterwasser of Pülna for six weeks, he experienced a marked improvement. The steady application of electricity completed the cure in this case also. The blue line of Burton was observed in the gums of this gentleman.

Dr. Meyer observes that in these four cases of saturnine poisoning by snuff there existed—1st, perfect integrity of the supinators, with more or less complete paralysis of the extensors; 2nd, the arching forward of the metacarpal bones; and, 3rdly, the yellowish faded hue of the face. In three cases repeated attacks of colic preceded the paralysis, in one they were entirely absent. In three cases the common extensors of the fingers had chiefly suffered, in one the deltoid.

The four persons whose cases are detailed had all taken the snuff which is most in use, "Bayer's Gebr. Bernard in Offenbach."

It now remained to prove the presence of lead in their snuff and compare it with others. The examination was performed by Simon of Berlin.

The result proved the presence of lead in the snuff, 0.78 to 1.78 per cent; it also appeared that the intervention of blotting-paper did not prevent the snuff becoming impregnated with the lead; moreover, that the use of tin-foil (*staniol*) was no protection, inasmuch as it frequently contained lead.

The addition of a solution of common salt, which is used for the purpose of moistening the snuff, promotes the solution of the lead and consequent contamination.

For the benefit of those addicted to snuff a list of the snuffs which contain lead and those which are free from the impurity are given, the analysis being made by Dr. Lewinstein of Heidelberg. We believe the snuff chiefly used in this country, popularly denominated "blackguard," is free from lead,

and so we hope for the sake of some of our friends who *largely* indulge in it, is that manufactured by Friburg, but we would strongly recommend them to avoid the pernicious powder which for its greater preservation is carefully packed up in lead. We have often suspected that the cases of colic which we occasionally meet and for which we cannot discover a cause may have been produced by lead which has found access to the body by some undiscovered road and in a few it may have been through the nostrils.

In conclusion we would observe, that successful as Dr. Meyer's treatment was, the cure would probably have been far more expeditious if in addition to the electricity, sulphureous baths, and mineral waters, he had employed the iodide of potassium, which, in our own hands, has proved of inestimable value in cases of saturnine poisoning.

RESTORATION OF PERSONS APPARENTLY DROWNED.

The Committee of the National Life-Boat Institution are anxious to obtain information from medical men who have attended persons apparently drowned, as to the comparative value of the two methods of treatment.

ROYAL HUMANE SOCIETY'S INSTRUCTIONS.

SEND QUICKLY FOR MEDICAL ASSISTANCE.—*Cautions.*—1. Lose no time. 2. Avoid all rough usage. 3. Never hold up the body by the feet. 4. Nor roll the body on casks. 5. Nor rub the body with salt or spirits. 6. Nor inject tobacco smoke nor infusion of tobacco. I. Convey the body carefully, on its face, with the head and shoulders supported in a raised position, to the nearest house. II. Strip the body, and rub it dry; then wrap it in hot blankets, and placed it in a warm bed, in a warm chamber free from smoke. III. Wipe and cleanse the mouth and nostrils. IV. In order to restore the natural heat of the body: Move a heated covered warming pan over the back and spine. Put bladders or bottles of hot water, or heated bricks, to the pit of the stomach, the arm-pits, between the thighs, and to the soles of the feet. Foment the body with hot flannels. Rub the body briskly with the hand; do not, however, suspend the use of the other means at the same moment, but, if possible, immerse the body in a warm bath at blood heat, or 100° of the thermometer, as this is preferable to the other means of restoring warmth. V. Volatile salts or hartshorn to be passed occasionally to and fro under the nostrils. VI. No more persons to be admitted into the room than are absolutely necessary.

If apparently Dead from intense Cold.—Rub the body with snow, ice, or cold water. Restore warmth by slow degrees, and after some time, if necessary, employ the means recommended for the apparently drowned. In these accidents it is highly dangerous to apply heat too early.

General observations.—On the restoration of life, a tea-spoonful of warm water should be given; and then, if the power of swallowing be returned, small quantities of wine, or diluted brandy, warm. The patient should be kept in bed, and a disposition to sleep encouraged, except in cases of apoplexy, intoxication, and coup-de-soleil. Great care is requisite to maintain the restored vital actions, and at the same time to prevent undue excitement.

The Treatment recommended by the Society to be

persevered in for *three or four* hours, as it is an erroneous opinion that persons are irrecoverable because life does not soon make its appearance, cases having come under the notice of the Society of successful results even after five hours; and it is also absurd to suppose that a body must not be meddled with or removed without the previous permission of a coroner.

DR. MARSHALL HALL'S INSTRUCTIONS.

1. Treat the patient instantly, on the spot, in the open air, exposing the face and chest to the breeze (except in severe weather).

I.—*To Clear the Throat.*—2. Place the patient gently on the face, with one wrist under the forehead [all fluids and the tongue itself then fall forwards, leaving the entrance into the windpipe free.] If there be breathing wait and watch; if not, or if it fail—

II.—*To excite Respiration.*—3. Turn the patient well and instantly on his side, and 4. Excite the nostrils with snuff, or the throat with a feather, &c., and dash cold water on the face previously rubbed warm. If there be no success, lose not a moment, but instantly—

III.—*To imitate Respiration.*—5. Replace the patient on his face, raising and supporting the chest well on a folded coat or other article of dress. 6. Turn the body very gently on the side, and a little beyond, and then briskly on the face, alternately, repeating these measures deliberately, efficiently, and perseveringly, fifteen times in the minute, occasionally varying the side [when the patient reposes on the chest this cavity is compressed by the weight of the body, and respiration takes place; when he is turned on the side this pressure is removed, and inspiration occurs.] 7. When the prone position is resumed, make equable but efficient pressure, with brisk movement, along the back of the chest, removing it immediately before rotation on the side [the first measure augments the expiration, the second commences inspiration.]

The result is—respiration, and, if not too late, life.

IV.—*To induce Circulation and Warmth.*—8. Meantime rub the limbs upwards, with firm grasping pressure and with energy, using handkerchiefs, &c. [by this measure the blood is propelled along the veins towards the heart]. 9. Let the limbs be thus warmed and dried, and then clothed, the by-standers supplying the requisite garments. 10. Avoid the continuous warm bath, and the position on or inclined to the back.

TRANSACTIONS OF THE SWEDISH SOCIETY OF PHYSICIANS.

Case of concretion on the nervous vagus, in a diabetic patient. By Hr. Nyman.—Early in the morning of the 24th of August, I was requested by Dr. Zanteson to accompany him to a Notary D., who had taken suddenly and violently ill. On our arrival we found the patient in a semi-comatose condition, with a small, weak, and rapid pulse, cold extremities, and stertorous respiration. He was unable to give an account of himself, and in answer to questions uttered merely some unconnected words. Dr. Zanteson now explained that the patient had long suffered from diabetes mellitus, for which he had last spring been under treatment, at the Seraphim Hospital, and had afterwards, during the summer, taken the waters at Carlsbad, whence he had lately returned home. From a person living in the next room to Notary D., we learned that after his return from Carlsbad, he had lived rather freely, and had, for the last two days, complained of feeling rather indisposed, but that he had, nevertheless, constantly attended to his business, and was sprightly and cheerful. On the afternoon of the 23rd, he, for the first time, complained of headache and oppression of the chest, and of shiverings alternating with febrile heat. However, no one had been with him during the night, and in the morning

the chamber-maid first found him in the state above described.

At a time when cholera was prevalent, it was natural to suspect that this sudden and violent attack was one of that disease. A glance at the patient was, however, sufficient to dissipate such an idea. The face was bloated and red; the patient had had neither vomiting nor diarrhoea, on the contrary he had for several days suffered from constipation; the urine was voided in considerable quantity; there was neither cramp, hoarseness, nor any other symptom indicative of cholera. We now made an accurate physical examination, but could discover nothing abnormal in either the thoracic or the abdominal cavity; still all the symptoms indicated a speedy and fatal termination of the case. Death occurred in the afternoon of the same day. Dr. Zantesson now informed Professor Huss, under whose care the deceased had been in the hospital, of his death, who requested us, at the *post-mortem*, accurately to examine the *nervi vagi*, in reference to the diabetes, under which the patient had laboured.

The autopsy took place on the following day, the 25th of August, Doctors Sydow, Granberg, and Lundberg, also being present.

The state of the principal internal organs was as follows:—The membranes of the brain were highly congested with blood; there was no effusion either under the arachnoid or in the ventricles. In the summit of each lung were some few scattered crude tubercles, there were no miliary granulations. The heart, relaxed and flaccid, contained a little coagulated blood in the right ventricle. The pleura and the pericardium were slightly adherent. The blood in the larger thoracic vessels was dark and thick. The stomach, which was considerably dilated, contained some spoonfuls of dark fluid, in which half-digested white bonum magnum plums were floating. In the small intestines was no trace of fluid; the mucous membrane was covered with a little yellowish-brown mucus. The transverse and descending colon were filled with masses of solid excrement. The kidneys were hypertrophied and congested with blood. The ureters were dilated. The bladder considerably enlarged, contained more than a pound of urine. The liver was of natural size; its substance was flaccid and loaded with blood.

After we had examined the above-named organs, we commenced the dissection of the *nervi vagi*. On the left nothing abnormal could be found, but on examining the right, we met, in the thorax, immediately behind the bifurcation of the bronchi, a calcareous mass of the size of a hazel-nut, which was under the entire trunk of the nerve, and appeared to have exercised considerable pressure upon it.

This morbid condition now observed by us for the third time,* in persons dead of diabetes, gives additional support derived from pathology to the truth of the ingenious Bernard's well-known physiological doctrine. It may indeed be objected that the *nervus vagus* has other functions than the formation of sugar in the liver to perform, and that these functions also ought to be disturbed by a mechanical pressure on the *vagus*. But is not this, perhaps, in some measure the case in diabetes mellitus? The voracity at least accompanying this disease, seems also to depend on irritation of the *vagus*, which presides over the secretion of the gastric juice.

Before closing this statement, I may be permitted to suggest a theory of the origin of these calcareous concretions on the *vagus*. The calcareous concretions we met in this case, bore at first sight a striking resemblance to a bronchial gland, and such it was found on close investigation really to be. Was, then, this ossified bronchial gland anything else than a blighted tubercle? At least we may thus easily and naturally explain, not only the formation of such calcareous masses on the

vagus, but also the near connexion, so long observed, between tuberculosis and diabetes.

Hr. Huss mentioned that the person in question was under treatment in the hospital for four or five months, in the latter part of last year, and the beginning of the present. The urine then contained six or seven per cent. of sugar. The appetite was inordinately great. The quantity of urine often amounted to about three quarts (5 à 6 kanner), in the twenty-four hours. The urine contained no uric acid. Both ordinary and extraordinary means were employed; among others yeast. Astringents with opium somewhat diminished the quantity of urine. By the advice of Hr. Huss the man went in the beginning of summer to Carlsbad, although the prospects of improvement were not great, the uric acid being absent. On his return from Carlsbad, he visited Hr. Huss, and looked tolerably well, but in other respects circumstances were unchanged. It is universally admitted that there are several forms of diabetes which cannot be distinguished until after death. The present case, so strongly confirmatory of Bernard's views, is an interesting example of one of these forms. With respect to the nature of the concretion, Hr. Huss fully concurred in Hr. Nymán's opinion. It is, however, remarkable, that only the formation of sugar should be disturbed by such pressure on the *vagus*, and that other functions dependant on that nerve, as those of respiration and digestion, should not be in any way interfered with. The insatiable appetite in this case ought also certainly to be regarded as a consequence of the affection of the *vagi*.

To a question by Hr. Carlsson, whether uric acid was also absent in the two cases previously communicated to the society, in which, on *post-mortem* examination, concretions were found on the *vagus*, Hr. Huss replied that he was not able to give any positive information as the subject.

Hr. V. Lundberg communicated the following cases and reports of post-mortem examinations, and exhibited the several pathological preparations belonging thereto.
Case 1.—*Atresia ani and hydrocephalus*.—E. H., was born in March, 1854, with *atresia ani*. She was not operated on until after the lapse of a day and a half, medical assistance not having been sooner sought. There was no depression over the usual situation of the anal opening, but the raphe was continued evenly over the same. The operation was performed by incision and dissection, and the intestine was felt distended at the depth of three quarters of an inch. Its incision was immediately followed by a discharge of meconium, and the wound was kept open by means of a conical dilator of horn, until the edges were healed. The child continued well, and had regular evacuation during the entire summer. In autumn it was discovered that she had congenital blindness, and that she presented symptoms of chronic hydrocephalus. The anal opening showed some tendency to contract, which was, however, easily removed by dilatation. The cerebral affection increased during the first days of December, and the child died on the 4th of the same month. On *post-mortem* examination, it was found that the colon was contracted in its entire length, with the exception of the lumbar and left iliac portions, which were dilated into the form of a sac; the rectum was of the normal capacity, and the anal orifice remained open and permeable, though somewhat narrow. Subsequently to the operation the external skin had turned inwards, and replaced the deficient mucous membrane.

Case 2.—*Stricture of the colon and chronic peritonitis*.—Fru S., 54 years of age, was said to have suffered for years from obstruction and so-called hemorrhoids, without having applied for medical advice. A year before her death, during the prevalence of cholera, I was called to her, the messenger stating that she was labouring under fully-developed cholera, which had already passed into the blue stage. On examination I found, however, that she was suffering from

* See DUBLIN HOSPITAL GAZETTE, July 1, 1857, p. 207.

well-marked peritonitis, which I considered to be the result of a perforating ulcer, neither herself, nor any of those about her, being able to give any information as to her antecedents. Under opium treatment she recovered, and I lost sight of her for a long time. In September of the present year, she visited me once, when, on closer examination, I came to the conclusion that she was suffering from ulcerative stricture of the colon, which could not, however, be reached per anum with the finger. Her habit and cachectic appearance induced a suspicion that this constriction was probably of a malignant nature. I prescribed some remedies, and heard no more of her, until I was, six weeks' subsequently, summoned to her death-bed. The violent vomiting and abdominal pain, and the rapid supervention of cyanosis with icy coldness, led those about her again to suppose that her case was one of cholera. The symptoms, as on the former occasion, indicated peritonitis after perforation, now evidently produced by the constriction, for the colon was strongly distended in its whole extent. She died on the same day. On dissection a fibro-cartilaginous constriction, ulcerated throughout three-fourths of its cavity, was discovered, situated in the lower part of the sigmoid flexure, but too high up to be reached by the finger. The ulceration did not, on microscopic examination, exhibit any carcinomatous degeneration. At the superior boundary of the constriction were found two openings into the peritoneum, together with the cicatrix of an old opening, covered externally by a little fatty tumor. The fæces were effused into the peritoneal cavity, in which were found signs of acute inflammation, and both old and new adhesions. The colon was enormously distended. In the uterus was a small fibrous tumor, but there was no other sign of any degeneration.

Case 3.—*Tuberculosis of the kidney*.—Mamsell E. A., aged 34, in 1851 began to suffer from difficulty in passing water, with which occasionally blood was voided. She recovered tolerably, and continued well, until February of the present year, when, without any return of difficulty in micturition, she observed that the urine was mixed with pus. She was for some time treated homoeopathically. On the 16th of April, I saw her for the first time. The urine was then mixed to the amount of one-third with pus, and her condition was hectic. On examination of the abdomen, a large tumor was found, extending from the region of the spleen down towards the left epigastrium; it was tender to the touch, and yielded a dull sound on percussion. The entire of the region of the kidney was hard and tense. In the lungs were crude tubercles. I then considered either (and most probably) that the kidney had been primarily diseased and had passed into suppuration, or that a tumor, situated between it and the spleen, had suppurated and opened into the kidney, through which it discharged its pus. The symptoms attending the first occurrence of the disease were in favour of the first; the great extent of the tumor in the anterior part of the abdomen, and the reported absence for many years of pus from the bladder, were in favour of the second view. Bark, acids, and opium diminished the hectic, and the secretion of pus and the pains were not so great as to prevent the patient from getting up every day, and, when the temperature became milder, going out into the garden. In June the distention of the side increased, and on examination an obscure fluctuation was perceptible in the region of the spleen. After a consultation, I made a puncture with a large exploring probe, and gave exit to about half a pint of greenish-yellow matter. This was followed by no reaction, the distention of the side was relieved, and the tumor diminished considerably in circumference. The amount of pus in the urine was also much lessened. The patient subsequently spent two months in the country, and I did not see her again until the middle of September. She then reported that her health during the summer had been tolerably good; the pains had not been considerable, and she only begged of me to re-

lieve her weakness. On examining the abdomen I found that the tumor had increased, and had exceeded its former extent, presenting, at the same time, an obscure sensation of fluctuation. The region of the kidney continued hard and tender to the touch. On examination the patient complained, at the same time, of slight tenderness in the region of the liver, where the abdomen was, moreover, hard and tense, and even the slight degree of percussion which she could bear, indicated effusion. The hectic symptoms now gradually increased, with signs of extensive chronic peritonitis. In the beginning of November, the patient was attacked with violent diarrhoea, along with which a large quantity of pus was voided per anum, and the sensation of abdominal tension was again much relieved. The diarrhoea subsequently returned a couple of times, the patient's strength gradually diminished, and she died on the 3rd of December. Leave to open the abdomen was with difficulty obtained. All the intestines were found matted together, by products of inflammation. In the region of the spleen was a large cavity surrounded by a dense pyogenic membrane, and containing about three half pints of pus, in which swam large lumps of cheesy matter. This cavity communicated with the left kidney, through a large opening, half filled with the above-mentioned lumps. The kidney was two or three times its natural size, and was filled with half-dissolved tubercular matter, not merely in the pelvis, but also in all the calyces. The mucous membrane throughout was infiltrated with tuberculous matter and destroyed. The ureter proceeding from this kidney, down towards the bladder, was obstructed with the cheesy tuberculous matter just described. Under the liver was a large cavity likewise containing more than a pint of this pus, which cavity communicated with the other under the coalesced loops of intestine. In the pelvis too, around the bladder, the intestines were found to be pressed upwards by a large depot of pus, which at the sigmoid flexure exhibited traces of a communication with the large testine. The right kidney was normal, although somewhat hypertrophied; the mucous membrane of the bladder was healthy; the liver was ex-sanguine and flaccid; the spleen was small, pushed backwards, and atrophied by the pressure of the pus.

The previous symptoms are easily explained by the necroscopic phenomena. The kidney presented a perfect specimen of Rokitansky's "tubercle" in the kidneys, proceeding from its mucous membrane. During the very first stage of their development, blood occurred in the urine, and passed imperceptibly into pus. By more complete deposition and softening, the ureter became obstructed, partly in consequence of inflammation, and partly mechanically by lumps of pus; the kidney was first distended, and then burst, and emptied its contents into the abdominal cavity; henceforward the discharge of pus with the urine was diminished. From this newly-formed tumor-like cavity, I drew off, in June, the pus through a puncture, and after this had, in the course of the summer, again over-filled itself, the pus spread to other parts of the abdomen. The communication finally formed, though again closed, with the purulent depot in the true pelvis, explains the purulent diarrhoea.

It is extraordinary that a human being could live so long with such changes and progressive inflammation in the abdomen; that the intestines, matted together for eight or nine months, could discharge their functions; and that the patient's sufferings were on the whole so slight.

THE DUVAL PRIZE IN SURGERY.—This prize, annually adjudged by the Société de Chirurgie, of Paris, to the author of the best thesis published in France during the last year, has been this year conferred upon M. Caron, for his thesis on the "Treatment of Varix by the Injection of Perchloride of Iron into the Veins."

EXTRACTS FROM THE REPORT ON MATERIA MEDICA AND THERAPEUTICS,

In the British and Foreign Medico-Chirurgical Review, for July, 1857.

On Chloride of Gold and Sodium, employed as a Solvent in the Treatment of certain Tumors. By Dr. ROUAULT. (L'Union Médicale, Feb. 21st, 1857.)

The author of this communication relates some cases observed by Dr. Debreque and himself, in which it was found that the preparations of gold possess a special elective action in the treatment of glandular tumors. In chronic adenitis in general, and particularly in cervical adenitis, the solvent properties of the preparation alluded to appeared even more energetic and certain than those of iodine. One of the circumstances favourable to its employment is the presence of several tumors, separated or united in the form of a chaplet, or of ganglionic knots. The author remarked that its efficacy was less evident when there existed only a single ganglion, the resolution of which then only takes place with extreme slowness, and often not at all. Gold is also useful in benignant tumors of the breast, such as simple engorgement, hypertrophy, and sub-inflammatory tumors; and it also appeared to Dr. Rouault to be undoubtedly efficacious in certain tumors which were evidently of a malignant nature. The chloride of gold and sodium was the preparation generally employed, being combined with starch and gum arabic, and made into pills. With one of these pills friction was made every evening on the tongue, the gums, and the inside of the cheeks. The friction should be employed for some minutes, and the patient ought not to spit, so as to swallow any remains of the matter which is rubbed in. This plan is to be followed for at least six weeks. Several cases are related in which this plan appears to have been attended with success.

On the Preparation and Therapeutical Employment of Subcarbonate of Bismuth. (Bulletin de Thérapeutique, February 15th, 1857.)

The following is the mode of preparation of the subcarbonate of bismuth described by M. Hannon, Professor at the University of Brussels. The bismuth is first purified by melting this metal in powder with ten times its weight of powdered nitre. After cooling, the metal is again powdered, and mixed with ten times its weight of nitre, and after a second fusion the bismuth may be considered as entirely free from the arseniurets and sulphurets which it almost always contains. Then three parts of nitric acid are put into a retort, and one part of pure bismuth is added. When the reaction is complete, about a third of the liquid is evaporated, then the solution is poured drop by drop into a solution of carbonate of soda, and a white precipitate is obtained, which is subcarbonate of bismuth. The precipitate, after having been washed five or six times with distilled water, is thrown upon a filter, and washed again, to remove the last traces of carbonate of soda. It should be preserved in well-stopped bottles. The physiological properties of the salts of bismuth are very little known, for the simple reason that the subnitrate is the only salt which has been employed in medicine. The operation even of this salt is not well understood, as its insolubility offers an obstacle to the observation of the physiological phenomena which might have been observed in the other salts of bismuth, such as the citrate, the tartrate, the acetate, or the carbonate. It is also the insolubility of the subnitrate which renders it inefficient in the greater part of the cases in which it is indicated; and it also occasionally produces a very inconvenient sensation of weight at the stomach. The subcarbonate is soluble in the gastric juice, its action is rapid, it produces no sensation of weight at the stomach, it rarely

constipates, colours the stools less than the subnitrate, and may be employed for a long time without oppressing the stomach. The action of the subcarbonate appears to be sedative during the first days of its employment, and subsequently to excite all the phenomena which result from the action of tonics.

As to its therapeutical action, it may be noted that all cases of gastralgia consecutive upon phlegmasia of the digestive passages, cases in which the tongue is red and pointed, and cases in which the digestion is laborious and accompanied with putrid or acid eructations, or in which there is a tendency to diarrhœa or spasmodic vomiting, demand the employment of the subcarbonate of bismuth. This salt is also required in the vomiting of children, whether caused by dentition or succeeding to frequent fits of indigestion, and in the diarrhœa of weak children, especially when occurring at the time of weaning. One great advantage possessed by the subcarbonate of bismuth is, that it neutralizes the acids in excess which are found in the stomach. The subnitrate as is well known, fails always in this respect. In all the cases where the subcarbonate has been taken, the pain in the digestive passages is first found to disappear; then the eructations cease, together with the vomiting or diarrhœa; the digestion becomes less and less laborious, the tongue gradually receives its normal form and colour; and if the use of the subcarbonate is continued, the appetite increases from day to day, the yellow tint of the countenance disappears, and the face becomes coloured at the same time as it ceases to be shrivelled.

The subcarbonate of bismuth is perfectly insipid, and excites no repugnance. It is given before meals. Adults take it in a little water, and children in honey. It may also be made into lozenges. The dose for adults is from one to three grammes, taken three times a day, in increasing doses.

On the Curative Properties of Sulphureous, Ferruginous, and Alkaline Springs. (L'Union Médicale, April 4th, 1857.)

In a late discussion at the Société d'Hydrologie Médicale of Paris, M. Cahen discussed the question, whether sulphureous, ferruginous, and alkaline springs possess any other curative properties besides those possessed by sulphur, iron, and bicarbonate of soda; and he comes to the conclusion that the benefit arising from the use of such waters is of a strictly physiological and chemical nature, and is due to the presence of the mineral which is held in solution. It is true that there are accessory circumstances which are not to be neglected in considering the effects of mineral waters in the restoration of health,—such as the journey—the change of air, of diet, and of habits—the influence of amusement, and even of hope; but these are not in themselves, except in special cases, sufficient for effecting a cure. In explaining the influence of mineral waters, however, an exclusively chemical view of their character is to be deprecated; for the human system in contact with such waters cannot be regarded in the same light as a chemical experiment made in the laboratory, where the conditions of the experiment are fixed and constant. Thus the Vichy waters, acting upon the mucous membrane of the stomach affected with pyrosis, attended with hypersecretion of alkaline matters, are not to be regarded as an alkaline fluid saturating an excess of alkali; for physiology has shown that in contact with a small quantity of alkaline water, the mucous membrane of the stomach secretes abundantly acid gastric juice, and it is this acid gastric juice which removes the inconveniences of an abnormal secretion. The water acts only mediately in this case, by the reaction which it has excited. It has also been said, that while mineral alkaline substances introduced in excess into the economy produce an alkaline cachexia, yet gouty persons drink every day and for a long time enormous quantities of Vichy water without the slightest inconvenience.

Now this happens *because they are gouty*, and because there exists in them an acid diathesis which opposes the influence of alkaline drinks. M. Cahen concludes his observations by remarking that, in his opinion, there is nothing latent or mysterious in the action of these waters, and that they act, on the one hand, in a physiological manner, and, on the other hand, by virtue of the mineral substances which they contain. In the course of the discussion which followed the remarks of M. Cahen, M. Durand-Fardel denied the accusation sometimes brought against the Vichy waters, that they had often induced an alkaline cachexia; and he stated that he had himself lived at Vichy ten years, and had seen a great number of persons take the mineral waters in excess, and suffer inconvenience from so doing, but had never observed anything approaching to what has been described as alkaline cachexia. M. Cahen, on the other hand, although admitting that gouty persons are with difficulty rendered cachectic by the use of the Vichy waters, contended that this cachexia did really exist. He himself had employed immediately the waters and the baths of Vichy, and he fell into a distinctly asthenic state; his blood, drawn from a vein, presented a defibrinated appearance. He also stated that the inhabitants of Vichy are of squalid appearance, which circumstance may be attributed to their habit of using the waters in their daily occupations.

Balneological Sketches. By Prof. LÖSCHNER, of Prague. (Vierteljahrsschrift für die Praktische Heilkunde, 1857.)

Prof. Löschner, after some remarks upon the operation of the gases introduced into the lungs by the breath during bathing, describes the operation of certain baths in the cure of disease. He treats first of the operation of the Marienbad springs in the diseases of children. It should be premised that the diet of all the patients was regulated upon a uniform scale. The Kreuzbrunnen and Ferdinandsbrunnen of Marienbad are found efficacious in scrofulous affections of the glands, of the skin, of the bones, with and without the appearance of reaction; glandular inflammation in different parts of the body, formation of abscess, caries, ulceration of the cornea, eczema, herpes, psoriasis, zoster. The operation of these waters is shown by constant increase of the functions of the intestines and kidneys, with appearance sometimes of the formation of sulphuret of iron, and development of sulphuretted hydrogen, together with remarkable secretion of bile, sometimes of uric and oxalic acids, particles of fat, shreds of mucus, diminished excretion of phosphoric acid, and afterwards decrease of the weight of the body, but nevertheless increased vital activity, in combination with powerful changes in the whole process of nutrition. The latter is especially shown in the vivacity of the children, which at first is diminished, but is subsequently increased; in their better and purer colour; in the disappearance of glandular tumors (unless when they are infiltrated with tuberculous masses); in the diminished swelling of the bones; in the drying-up of chronic exanthemata; in the discontinuance of inflammatory symptoms in the eye and ear. The activity of the heart and arteries was augmented, the tympanitic condition of the abdomen subsided, the mental operations became active and lively. The mode of operation of the Marienbad springs, in accordance with their chemical peculiarities, may be stated to consist in bringing about a more active metamorphosis of tissues, acceleration of the digestion, normal conversion of the nourishing material into the organic juices, and more powerful nutrition by means of the increase and improvement of the constituents of the blood. Dr. Löschner then describes the use of the iodine water of Halle and Fracchia's sea-baths in children's cases. The diet should first be regulated, by allowing a copious supply of meat and a limited quantity of vegetables. The subjects most appropriate for treat-

ment in these baths are those suffering from torpid scrofulous affections, and rachitic patients with a high degree of swelling of the epiphyses; the former in the most intense form of abdominal, cutaneous, and glandular scrofula; the latter being cases of long duration, and already beginning to exhibit ossification of the swellings of the epiphyses. The author knows no mineral water containing iodine which exhibits its operation so powerfully and so quickly upon the organism as that now described; and this effect he attributes to the absorption of iodine into the system. Baths with the iodine water of Halle and the artificial sea-baths soon produce, when used continuously and in a concentrated form, powerful symptoms of reaction, and the appearances of iodism, with tumultuous and reducing metamorphosis of tissues; while baths of moderate temperature, of brief duration, employed every second day, may be continued for weeks, and even months, without producing such a tumultuous operation, and accomplish, in a tranquil manner, the changes of the tissues. It is remarkable and surprising, under such circumstances, to observe the disappearance of scrofulous tumors, of chronic catarrhs of the nose, throat, and genital mucous membrane depending upon a scrofulous origin, such as scrofulous ozæna and utero-vaginal catarrh; the subsidence of swellings of the epiphyses in rachitic patients, with striking improvement of the aspect after a moderate previous excitement of the function of the skin, and the separation of abnormal quantities of mucus, with salts of uric and oxalic acid, through the respiratory and urinary organs. Dr. Löschner found the iodine waters of Halle very useful, when employed internally, and when inhaled by the nostrils, in a case of long-continued ozæna in a young woman approaching puberty, in whom for many years a great number of remedies had been employed in vain; also in glandular swellings of the abdomen; in chronic utero-vaginal catarrh, in which artificial sea-baths and the internal use of the iodine water have effected a complete cure; and in chronic exanthemata of scrofulous children, in which this water is a most powerful remedy. Latterly, Dr. Löschner has made some experiments with the iodine water of Halle in the syphilis of children, using at the same time the artificial sea-baths; if exanthemata were present at the same time. Four cases only of this kind of treatment have been observed; but they appear to the author to justify him in the belief that the operation of the water is also beneficial in these maladies.

On the Employment of Electricity in the Suppression of the Lactæal Secretion. (L'Union Médicale, January 3rd, 1857.)

M. Becquerel, in a late communication to the Société Médicale des Hôpitaux de Paris, has made some remarks upon the influence of electricity in restoring the secretion of milk. His attention was called to the subject by a case related to him by M. Aubert, who had employed electricity in the case of a young woman whose milk had been suppressed in consequence of a double pneumonia. The electricity was applied to the breasts by means of moist excitors, and after four applications, each lasting twenty minutes, the lactæal secretion was completely restored. M. Becquerel was at first incredulous as to the reality of the result; but the following case, which fell under his observation, removed his doubts:

A young woman, aged twenty-seven, well formed, although of a nervous temperament, had suckled a young infant for six months, but, on the occasion of some intense and often-repeated mental emotions, the lactæal secretion diminished considerably; the right breast retained a little milk, but the left was almost completely dried up. M. Becquerel applied the electrical current at first to the left breast, placing the moist excitors, made of sponge, successively in the dif-

ferent points of the circumference of the breast, so that the currents might traverse the organ in all directions. Three applications were made, each lasting a quarter of an hour. The patient suffered very little, and indeed experienced little more than a feeling of inconvenience. From the time of the first application, the rush of milk supervened almost immediately after the application of the electrical currents. After the third application, the secretion was full and entire; the child had taken the breast, and the milk was abundant in the left breast, and sufficient in the right to obviate the necessity of applying the electricity on that side.

On a Case of Diabetes treated by the Use of Rennet.
By Dr. IVERSEN. (Archiv des Vereins für Gemeinschaftliche Arbeiten, 1856.)

Dr. Iversen relates the case of a patient, in the lower class of life, who had well-marked diabetes, who was treated with rennet, and the details of whose case were carefully recorded day by day. As all the usual plans of treatment had been unsuccessful before the patient's admission into the hospital under Dr. Iversen's care, he made an experiment of the rennet treatment. In order to obtain as accurate a result as possible, it was determined, in the beginning of the treatment, not to alter the diet of the patient, except to recommend the greatest possible abstinence from drinking. By the table prepared by Dr. Iversen, the treatment seems to have been successful in diminishing the quantity of sugar in the urine; but from some circumstances which are not explained, the patient was seized suddenly during the progress of the case with fainting, followed by spasms, ending in death. No *post-mortem* examination was permitted, and the case is therefore imperfect. Notwithstanding the unfortunate result, Dr. Iversen considers that the constant diminution of the urine, both in its actual quantity and in its saccharine ingredient, was very remarkable. He shows that in the first four days, during which the patient took no medicine, the average quantity of urine voided amounted to 10·108 cubic centimètres. In the following period of seven days, during which she took the rennet, the quantity of urine reached only 7·927 cubic centimètres, with a quantity of sugar amounting to 324 grammes. In the next five days, during which she took the rennet in combination with phosphate of soda, the average daily quantity of urine sank to 6·988 centimètres, with 250·317 grammes of sugar. The patient herself attributed to the rennet the power of allaying in some measure the burning thirst which she experienced.

On the Use of Sulphate of Atropia in Diseases of the Eye. By Dr. FRIEDRICH MOSLER. (Archiv des Vereins für Gemeinschaftliche Arbeiten, 1856.)

As the result of practical investigations upon the use of sulphate of atropia in ophthalmic medicine, Dr. Mosler arrives at the following conclusions:—1. That the sulphate of atropia is preferable to the pure alkaloid for therapeutic purposes. In a state of purity the sulphate, employed with the necessary precautions, even in large doses (such as five grammes to an ounce of distilled water), produced no unfavourable effects upon the eye. In using it, care must be taken of the absorption of the tears running from the eye and mixing with the solution, and the absorption of the solution itself is to be guarded against. 2. In ophthalmoscopic investigations atropia has rendered especial services in many cases; in order to diminish as much as possible the inconvenience felt by the patient in its use, attention must be paid to the investigations of Donders, upon the more or less enduring operation of the different strong solutions. The employment of atropia is not *a priori* to be recommended in every ophthalmoscopic investigation. 3. In inflammatory states of the eye, especially those characterized by violent pain, intolerance of light, and abun-

dant lachrymation, as particularly in injuries of the eye with or without affection of the iris, we have been acquainted with atropia as an essentially soothing agent, as by its operation on the sensitive nerves of the eye it possesses the power of removing rapidly the state of excessive irritation. As a decided remedial agent, it appears moreover to act by its operation upon the motor nerves in the eye, inasmuch as, according to the explanation of Dr. Von Gräfe, it paralyzes the muscles which are found in and about the eye, and which in such cases exercise an excessive pressure upon the internal structures of the eye, and in consequence of the return of the blood being impeded, give rise to accumulation of blood in those structures. It is thus explained why abscesses of the cornea under its use are less perforating and more easily healed, and why hypopyon is more rapidly absorbed. 4. Astringent eye-waters, especially the stronger cauterizing fluids, are better borne, and are attended with more rapid success, when the excessively heightened sensibility of the eye, which exists in the cases where this remedy is applicable, has been previously deadened by atropia. 5. Cauterization of the eye, employed only once daily with all necessary precautions, is better borne in many cases than the more frequent instillation of eye-waters, which every time appear to induce a new and well-marked irritation.

On the Employment of Iodide of Calomel (Chlorure Mercurieux) as a Local Application in Uterine Engorgement. By Dr. F. ROCHARD. (L'Union Médicale, January 6th, 1857.)

Dr. Rochard having applied the iodide of calomel in certain hypertrophic and sub-inflammatory affections of the neck of the uterus, has arrived at the following conclusions in favour of this kind of medication.

When a pledget of charpie, covered with a pommade of iodide of calomel, is applied to the neck of the engorged uterus, ulceration being absent, the women in general experience no particular sensation, but sometimes they feel towards the conclusion of the application a slight sensation of heat in the hypogastric region; when ulceration exists the sensation of heat is manifested very early, and is habitually followed by pains which may be rather severe. As soon as the dressing is removed, the sensation or even the pains are immediately relieved, and the neck of the uterus when examined appears more voluminous than before. If it is not ulcerated, there is formed upon all the surface of the mucous membrane touched by the pommade a thin exudation of a greyish-white colour, and of a consistence rather less than that of boiled albumen, which when examined by the microscope, exhibits neither pus nor epithelium, nor fibres, but only a granular, transparent, and apparently amorphous mass. When the neck is ulcerated, the same exudation is formed, but it does not remain adherent to the mucous membrane, and is removed with the dressing; in this case it contains some remnants of deformed epithelium. Besides this exudation, the charpie which has served for the dressing is always moistened with a serous liquid, sometimes sufficiently abundant to flow outwards and to form greyish spots upon the patient's linen. In the days succeeding the dressing, the exuded coagulum is detached by degrees, the volume of the os uteri diminishes, and becomes less than it was before the topical application; if there was any induration, which is generally the case, this induration is much less from the day succeeding the dressing. At the end of eight, ten, or twelve days, if the amelioration has made no progress, the dressing is renewed, and gives rise to the same phenomena, although in a less marked degree; and after two, three, four, or five applications made at the same intervals, the os is usually restored to its normal volume, and the ulcerations are cicatrized. The patients, who feel themselves *less heavy* on the first application,

are relieved from all painful sensations, particularly those who had no ulceration. The latter recover only after a longer period; the others can generally walk with ease after the second application, even when walking was previously impossible. The mode of applying the pommade is by preparing a pledget of charpie of suitable thickness, and of rather larger dimensions than the volume of the os uteri. The centre alone is covered with a light layer of the pommade, so that the edges which remain dry defend the vaginal mucous membrane from the contact of the application, which might cause inflammation.

On the Treatment of Scrofulous Affections by the Iodide of Potassium. (L'Union Médicale, February 17th, 1857.)

Dr Vincent Duval adopts the following plan in the administration of iodide of potassium in infantile scrofula. In children from one to three years of age, he prescribes the iodide of potassium in solution in distilled water, in the dose of ten to fifteen centigrammes a day during the first week, and of twenty to thirty in the three succeeding weeks. At the end of this time he discontinues the use of the drug for a week, and during this interval he purges the patients with castor oil, or preferably with calomel. Then he recommences the use of the iodide as before. At the end of two months, if the digestive passages are in an unfavourable condition, he orders one or two grammes a day of bicarbonate of soda, dissolved in sugared water or the infusion of hop. After a fortnight or a month of the use of the bicarbonate, he returns, if necessary, to the employment of iodide or bromide of potassium for one or two months. In children of more advanced years, the dose must be augmented in proportion; but even in adults, Dr. Duval seldom gives more than one gramme in a day. He often adds to the iodide of potassium the sulphate or the citrate of iron, more frequently the latter. When the patients are thin and weak, cod-liver oil agrees very well, not only as an iodized medicine, but also as a fatty body; it renders the blood more plastic and more fibrinous, the respiration more active, and the absorption of oxygen more abundant. (Given at the same time with the iodide of potassium, this latter medicine does not cause emaciation in the patients. If citrate of iron is added, independently of the iodide of potassium, its action is still further augmented. [Combinations, ready prepared, of cod-liver oil with iodide, iron, and other alteratives and tonics, have been long employed in British practice.—REPORTER.]

FEVER IN LONDON.—It appears from the Report of the London Fever Hospital for 1856, that the daily average of patients in the Hospital throughout the year was about 110, by far the largest number admitted into the Hospital in any year since its establishment, 55 years ago, exceeding by 300 the admissions in any former year. In regard to the types or forms of the fevers last year, there was nothing remarkable except the extraordinary proportion of typhus to typhoid, as compared with the three preceding years. The experience of the Hospital shows that typhus, strictly so called, is the most prevalent form, but this comparative prevalence varies in different years, as well as at different periods of the same year. Thus, in 1856 there were 1061 cases of typhus against 149 of typhoid (that form characterised by disease of Peyer's glands), being in the ratio of 7·11 to 1, while in the two preceding years (1854 and 1855) the proportion was only about 3 to 2, and 1853 it was in the ratio of 2 to 1. The greatest disproportion was observed in March and April, in which two months there were 275 cases of typhus and only 16 of typhoid admitted—being in the ratio of 17 of the former to 1 of the latter. Again, it was ob-

served that the months in which the two forms were most nearly equal were from August to November, the proportion in August being 1·4 of typhus to 1 of typhoid. Of that form of fever to which the term *fibracula* has been given, characterised by the mildness of the symptoms, the absence of peculiar rash, and of any organic complication, there were 89 examples, all of whom recovered. The numbers admitted with scarlet fever were 183, being a slight increase as compared with the cases received in 1855. It was most prevalent in April and October, the admissions being 31 and 26 respectively. In regard to the acute diseases *not* fevers, they were, as usual, acute affections of the various internal organs, with accompanying or symptomatic fever. They consisted of diseases of the brain, inflammation of the lungs, tuberculous affections in various parts, erysipelas, and acute and chronic diseases of the kidneys. Of this class there was a large proportion—217. The mortality last year was 289, being out of the total numbers admitted and under treatment on the 31st of December, 1855 (1882), in the ratio of 15·3 per cent., including, of course, the deaths from fevers as well as from other diseases. Of the cases of typhus under treatment (1117), the mortality was 204, or about 18 per cent.; of typhoid, it was 24 out of 180, or about 13 per cent. Of the 189 cases of scarlet fever, the deaths were 14, or 7 per cent. Of the other acute diseases *not* fevers (291), there were 47 deaths, or about 16 per cent. To show the severity of the cases, and, in too many instances, the hopeless condition of the patients when admitted into the Hospital, it may be stated that 152 patients died within a week after admission, and of those 27 did not survive 24 hours. Comparing the mortality of 1856 with that in the preceding year, the proportion of deaths was much smaller. In 1855 the gross mortality was nearly 17 per cent. (last year it was 15); that from typhus 25 per cent. (last year it was 18); from typhoid, 13 per cent. (last year it was nearly the same); scarlet fever was also less fatal last year than in 1855, being about 7·4 against 12·7 per cent.; while of the acute diseases *not* fever, the mortality was about 1 per cent. higher than in 1855. Notwithstanding the large number of patients in the Hospital last year, imposing necessarily increased labour on those in attendance on the sick, the nurses and inmates of the establishment have, with a few exceptions, escaped. One of the housemaids was seized with typhus, but she recovered. Three of the nurses were also the subjects of typhus, and they also recovered, as well as another nurse who passed through a mild form of scarlet fever.—*Medical Times and Gazette.*

A PAMPHLET has just appeared, by "A Member of the Royal College of Surgeons," recommending a practice which, however repugnant to some cherished notions, is worthy of attention on the ground of its sanitary tendency. The writer recommends a general recurrence to the practice among the Romans of burning the dead, instead of burying them, as is the custom in the present day. He represents in vivid language the abominations induced by intramural interments; and although the remains of the dead are now interred in spacious cemeteries, he shows that in no long period of time, at the present rate of mortality, and at the present rate of increase of the population, these receptacles will themselves become gigantic nuisances to the living. He proposes a decent and expeditious method of consuming the dead by fire, allowing the mephitic vapours to escape into the surrounding atmosphere, and retaining the ashes for collection and preservation in appropriate urns. We think that on scientific, and hygienic, and even on religious grounds, the author has entirely proved his case, although we doubt whether popular prejudices will allow of his plan being carried into effect, at least during the term of the present generation, and until the habit of burying the dead shall become such a positive and palpable evil as to call imperatively for removal. If once our dearly

cherished prepossessions could be amenable to the force of reasoning, it would be surely an easy matter to prove that the purifying influence of fire over our mortal remains is very far to be preferred to the slow, tedious, disgusting, and (to the living) dangerous process of allowing them to rot and corrupt in the earth, and by their putrid exhalations to poison the surrounding atmosphere.—*Medical Times and Gazette.*

In the list of pensions granted during the year ending June 20th, 1857, and charged upon the civil list, we find the following names:—

Dr. William Pultney Alison, £100, November 10th, 1856 (late Professor of the Practice of Physic in the University of Edinburgh), in consideration of his scientific attainments.

Mrs. Margaret Gavin, £50, November 15th, 1856, in consideration of the distressed circumstances in which she has been left on the death of her husband, Dr. Hector Gavin, who was accidentally killed in the Crimea, while employed in the public service.

Mrs. Lydia Falconer Miller, £70, June 19th, 1857, in consideration of the eminent services rendered to literature and science by the works of her late husband, Mr. Hugh Miller, and the straitened circumstances in which she is placed by his decease.

SURGEONS FOR THE ARMY.—The Minister of War has sanctioned a proposal that assistant-surgeons for service in the army shall henceforth be selected from a competitive examination. The examination will take place on Thursday, July 16th, and the vacancies to be filled up will be about twenty. Candidates must be British subjects, and under twenty-five years of age.

THE YELLOW FEVER is raging dreadfully in the West Indies amongst the shipping. The Atrato had had forty cases and twelve deaths. About fifty deaths had taken place amongst the Royal Mail Company's fleet. At St. Thomas the hospital was quite full with yellow fever cases.

THE CHOLERA.—Letters from St. Petersburg state that the cholera is gaining ground as the weather becomes warmer. The average number of deaths there at present is seventy per day.

APPOINTMENTS.

Dr. HATCHELL, surgeon to the Lord Lieutenant's Household, and surgeon to the constabulary depot in the Phoenix Park, has been appointed Joint Inspector-General of Lunatic Asylums in Ireland, in the room of Dr. White, who has resigned, in consequence of the shattered state of his health, from an accident on the Waterford and Kilkenny Railway, in November last. For this accident Dr. White has been awarded by a jury £2,500 damages and costs.

THE Lord Lieutenant has conferred on Eugene Le Clerc, Esq., for many years Medical Attendant of the Blackrock and Booterstown Dispensary, the office of Surgeon to the Constabulary Force in Ireland, vacant by the promotion of Dr. Hatchell to the Inspectorship of Lunatic Asylums. Mr. Le Clerc is a native of France, who studied in Ireland, and became a member of the College of Surgeons of England in 1844.

DR. DALY, Lecturer on the Practice of Medicine in the Hull and East Riding School of Anatomy, was appointed Physician to the Hull General Infirmary on June 26, in room of Dr. Horner, resigned.

DEATHS.

M. THÉNARD.—M. Thénard, whose death we lately recorded, was, as is known through Europe, one of the most eminent men of science of his time. He had been elevated to the peerage, was formerly Chancellor of the University of France, and died at

the age of eighty, June 20th last. At his decease he was member of the Academy of Sciences, and emeritus member of the Academy of Medicine. He was a great favourite of Lavoisier, the friend and pupil of Laplace and Berthollet, fellow-labourer with Davy and Berzelius, and the companion of Gay-Lussac. He taught by turns at the Sorbonne, the Ecole Polytechnique, and the College of France; and he has endowed his country with work on chemistry, which has remained for forty years, and passing through six editions, the most esteemed book on that science. M. Thénard possessed large property, which he used in a most generous and Christian manner, his last act of philanthropy being the foundation of a society for the relief of scientific men in distress, his first subscription amounting to £800. Dumas, who was twenty years ago the pupil of Thénard, pronounced over his tomb an eulogium full of grief and affection, by which all the assembly was deeply moved.

SESTIER.—Another of the rising celebrities of the Paris Medical community has been cut off, like his friend Valleix, in the prime of life. He had conquered an important position through the concours, and had produced an excellent monograph upon (Edema of the Glottis. He has left a valuable work upon the effects of lightning unfinished.

ALCIDE D'ORBIGNY.—This eminent naturalist, the celebrated Professor of Palaeontology at the Museum d'Histoire Naturelle of Paris, and so well known by his scientific travels in South America, died on the 30th ult., after a long and painful illness.

On the 15th ult., on board the Company's steam-ship Alma, of intermittent fever, Samuel Waudby, M.R.C.S. Eng., 1842; L.S.A., 1841, aged 37, Surgeon in the Peninsular and Oriental Company's Service, and late House-Surgeon at the Hereford Infirmary, during fourteen years.

On the 26th June, at Hastings, George West of No. 5, Northampton-place, Hackney-road, London, M.R.C.S., Eng., 1833; L.S.A. 1834; L.S.A. Dublin, 1831, third son of Jacob West, Esq., Loughlinstown House, Dublin, aged 55.

On July 5th, at Birmingham, Joseph Wickenden, M.R.C.S., Eng., and L.S.A. 1816; F. Geo. Soc., aged 62 years. He took a leading part with Sir Charles Hastings, M.D., in the formation of the Provincial Medical and Surgical Association, and was a member of its General Council up to the period of his death.

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LECTURES ON DISEASES OF THE STOMACH.

By DR. LEES,

Physician to the Meath Hospital, Lecturer on Practice
of Medicine.

DYSPEPSIA.

SYMPTOMS.—ACIDITY, HEART-BURN, PYROSIS, OR
WATERBRASH.

I will now proceed to make some observations on that very troublesome affection termed Dyspepsia or Indigestion, by which I mean a derangement in the performance of the natural functions of the stomach, quite independent of any organic or inflammatory disease of that viscus. As the symptoms it presents are very numerous I will merely consider a few of the most troublesome, enumerate the most suitable remedies for them, and then detail the general principles of treatment, warning you that you must constantly vary your treatment according to the cases, as they are often very difficult to manage. Excessive *acidity* of the stomach is a very constant and troublesome symptom, being more often met with, and in a greater degree, in its functional derangements, than in its actual diseases. The gastric juice, in a healthy stomach, ought to be merely secreted in sufficient quantity to act on the food, which if it be of an indigestible kind, or if detained too long in the stomach, then not only an excess of the natural acids (the muriatic and lactic) may be secreted, but other acids—especially carbonic acid—may be generated by a process of fermentation, which causes distention and flatulence. The best treatment for this condition is, first—to regulate the quantity and quality of the food, keep the bowels open by some warm aperient, particularly if the patient be of a gouty habit, give then a few grains of rhubarb, with one of capsicum, in a pill, just before dinner, and a few grains of bi-carbonate of soda, or potash, about one hour after meals. Let the drink be water; and if a stimulant be required, a little brandy or sherry well diluted, or aromatic spirit of ammonia in

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a little water. Another troublesome symptom of dyspepsia is *heartburn*, or cardialgia, characterised by a sensation of heat or acidity at the cardiac orifice of the stomach, often extending up the œsophagus, and sometimes accompanied by the regurgitation of an intensely sour fluid, or acid gas, very perceptible to the taste or smell. In most cases it comes on in from one to three or four hours after taking food, is a result of faulty digestion, and mostly met with in persons who lead sedentary lives, or have their minds actively engaged in business. But there is another form which comes on almost immediately after taking food, and often subsides as suddenly, so that it may be termed nervous, especially as it occurs chiefly in persons of a nervous temperament, and who have suffered from exhausting diseases, or mental depression. Dr. Chambers states that this form is often worse after the early than after the later meals of the day, even though the diet should be more sparing, and more digestible.

In this form of heartburn our great aim should be to remove the exciting cause, and invigorate the system by the preparations of valerian, iron, and quinine; but we should commence the treatment by some medicines which we know will act directly on the stomach, as bismuth, hydrocyanic acid, or morphia; but in the first form described, you will generally give relief by a few grains of bi-carbonate of soda or potash; and in some cases the mineral acids will effect a speedy cure. The late Dr. Prout was very partial to the use of these acids in this condition of the system, especially if there was much flatulence and palpitation, or irregular action of the heart after meals, and if oxalate of lime could be detected in the urine; and Dr. Budd says, that “they are often useful to persons in whom digestion is habitually slow and feeble from a scanty secretion of gastric juice, and who have a sense of weight, or oppression of the stomach after meals.”

Waterbrash, improperly termed *pyrosis*, is another very distressing symptom of dyspepsia, and consists in the regurgitation, or sudden gush of a watery or glairy fluid, often insipid, but sometimes

highly acid, so as to set the teeth on edge, not painful, but often giving a sensation of extreme cold. Dr. Cullen, who had much experience in this disease, states that its paroxysms "usually come on in the morning and forenoon, when the stomach is empty. The first symptom of it is a pain at the pit of the stomach, with a sense of constriction, as if the stomach was drawn towards the back. The pain is increased by raising the body into an erect posture; and therefore the body is bent forward. The pain is often very severe, and after some time an evacuation of this watery fluid, varying in quantity from a mouthful to a quart, or even more, takes place." The appetite may be good, but there is often thirst and emaciation. In most cases it is a functional disorder, and is accompanied by other symptoms of dyspepsia; but it may be symptomatic of organic disease of the stomach, or caused by an enlarged liver pressing on this viscus. It affects the female more than the male sex, and is especially liable to occur during pregnancy, if at an early period owing to the peculiar sympathy which exists between the uterus and the stomach; and when occurring at a late period it is probably caused by the pressure of an enlarged uterus on the stomach.

There is much difference of opinion as to the source of the fluid in pyrosis; but I believe it is a morbid secretion, derived (when acid) principally from the mucous membrane of the stomach. However, in these cases, it is not pure gastric juice, but consists of muriatic and lactic acids mixed with mucus and water; but if the fluid be alkaline, it is probably derived chiefly from the salivary and other glands in the mouth, and pharynx; for it then exhibits the ordinary characteristics of saliva, as it is alkaline and opalescent from the presence of the epithelium of the mouth and throat. Dr. Frerichs states, that it converts starch into sugar, and contains cyanide of potassium; so that in these cases it is more likely to be the secretion of the salivary glands, mouth, and œsophagus, rather than a watery discharge from the gastric mucous membrane. In fact, the discharge takes place in a healthy part by reflex irritation from a diseased one; but we cannot determine any fixed rules from the mere acidity or alkalinity of the secreted fluids. In some cases the fluid gushes into the mouth, without any spasm of the diaphragm, or previous warning; but in most, it is preceded by a sense of uneasiness at the epigastrium.

The causes of pyrosis may be divided into idiopathic and symptomatic. The first form, common to both sexes, often met with in the lower classes of society, is chiefly due to errors in diet; the second form is mostly met with in females of the better circles, and caused by some fault in the uterine or nervous system. If the diet has been too poor, or too farinaceous, we must improve it by giving a fair supply of animal food before we can expect any change; but if the uterine or nervous system be out of order, we must direct our remedies to

them in the first instance. In most cases there is an over secretion of mucus from the stomach, so that astringent medicines are of use, and of these bismuth, lime water, kino, catechu, rhatany, are useful. Nitrate of silver is of use, as it acts also on the nervous system; but a great objection to these medicines is, the constipation they occasion: so that we must keep the bowels open by enemata, or some aperient medicine, which will act on the intestines. Nux vomica is said to be a popular remedy among the Laplanders, who suffer much from this disease; and Dr. Budd says it may be given in pill, in the dose of from three to five grains, three times a day.

Mineral acids are often of great use, but they should be taken when the stomach is empty, as they check the morbid secretion of fluid by their immediate action on its mucous membrane, whereas alkalies ought to be given while digestion is going on, as they act by neutralizing the acid secretions, which are poured out during that process; so that "it is not irrational practice to prescribe regular doses of acids and occasional doses of alkalies for the same patient, but at different periods of the day, each medicine fulfilling a separate purpose."*

If severe pain be felt you must have recourse to sedatives, one or two drops of dilute hydrocyanic acid, with five grains of bi-carbonate of soda, in one ounce of water, will often give great relief, or ten to twenty drops of chloroform may be given, and if these fail, use opium, commencing with one-sixth of a grain three times a day, combined with extract of aloes. Dr. Pemberton was very partial to the compound powder of kino; but its efficacy was probably chiefly owing to the opium it contains, as it not only relieves pain, but also acts as an astringent, and checks the morbid secretion. In some cases, particularly those where the liver is deranged, from three to four grains of Plummer's pill every second or third night, will be useful; in other cases some of the preparations of iron are found to succeed; but no medicines can effect a cure unless great attention be paid to diet, which should consist of plain-dressed animal food, chiefly roasted, and eaten slowly with a small proportion of well-boiled vegetables. Fat, fried, baked or stewed meats, should be avoided, pastry, salads, acid or dried fruits, pickles, fermented liquors, and rich fish as salmon or herring. Some cannot eat potatoes without bringing on an attack; in others tea induces it. Sedentary habits predispose to it, particularly if the patient is closely confined to a desk, and obliged to work after dinner. These persons are sometimes sufferers from a form of rumination, owing to the solid food, particularly meat, regurgitating into the mouth at various intervals during digestion. It differs from vomiting, in not being preceded nor accompanied by nausea, or any violent expulsive effort. It is the same affection as that

* Child on Indigestion.

which has been so well described by Sir H. Marsh* as the "Regurgitant Disease," and which he conceives to be chiefly connected with hysteria and struma. But he states that, "in some cases of this singular affection there is present a symptom which indicates the co-existence of dyspepsia, viz., an oppression of the epigastrium;" and also he has met with cases characterised by severe gastrodynia, pain on pressure at the epigastrium, epigastric pulsation during digestion, gaseous distention and eructation, impaired appetite, and regurgitation not only of acid or bitter fluids but also of masses of half digested food. He recommends in these cases, a drop of creasote, with one-fifteenth or one-twentieth of a grain of muriate of morphia in pill three or four times a-day, with the compound aloetic pill as an aperient, or Prussic acid with or without a few drops of solution of muriate of morphia." Slow eating, perfect mastication, food well selected and restricted in quantity, constitute essentials in the treatment. In fact, these cases are to be regarded as forms of dyspepsia, and must be chiefly managed on general principles.

CLINICAL REPORTS OF SURGICAL CASES IN STEEVENS' HOSPITAL.

By SAMUEL A. CUSACK, F.R.C.S.,

Resident Surgeon, and Lecturer on Anatomy and Physiology in the Medical School of the Hospital.

Case of Foreign Body in the Œsophagus, for seventy-six days.

Kate Magourth, aged 4 years, was brought to hospital on the 1st of May, 1857, by her mother, who stated that four days previous she had swallowed a halfpenny, while playing with it. The mother stated that immediately after the occurrence she was able to feel the halfpenny when she passed her finger into the pharynx. An emetic had been administered before she was brought to hospital. On the 2nd of May, Mr. Harrison, assisted by Mr. Cusack and Mr. Colles, attempted to remove it with the long-curved forceps, and also with the probang, but without success; and it was doubtful whether the halfpenny could be felt or not. It certainly could not be distinguished by external examination. As it gave her little inconvenience, and she could swallow even solid food without difficulty, no further attempt was made to remove it, though the mother and child were both confident that it remained. The child returned home, and on the 12th of July, after swallowing a rather large morsel of food, had a fit of coughing, during which she coughed up the halfpenny. She was brought to Mr. Harrison's house immediately after, and appeared as well as ever, and quite free from any pain in swallowing. Mr. Harrison has the halfpenny in his possession: it is covered with a black

scale of the oxidized metal. From casts and other preparations in Mr. Harrison's museum, showing that the narrowest portion of the œsophagus is opposite to the sternum, he is of opinion that the halfpenny was lodged perpendicularly in that situation.

Case of Aortic Aneurism, producing Dislocation of the Heart towards the Spine.

John Hume, aged 40, was admitted into Steevens' Hospital on the 30th of May, 1857, for Thoracic Aneurism. Twelve months ago he observed that his breathing became short, and about the same time he felt a soreness in the right breast. He was able to continue at his work until three weeks ago, when he noticed a swelling in the place where he had felt the pain, which has been regularly increasing in size up to the present time. On admission, his breathing was difficult and stridulous; he had a ringing cough, and his face was livid; his pulse 80 and intermitting, but not appreciably different on either side of the body. There was an oval tumor on the right side of the chest, extending from the clavicle to two inches below the nipple, and transversely from the middle of the sternum nearly to the axilla. It was soft and elastic, and pulsated visibly, but no murmur could be heard in it; the respiratory murmur was absent from the whole of the right lung, except on the posterior surface, where it was confined to the bronchial tubes. On the left side it was puerile, and the sounds of the heart could not be any where distinguished, even when he held his breath. On one occasion Dr. Stokes examined him, and heard the heart when he was made to lean towards the left side. The thorax measured $16\frac{1}{2}$ inches on the left side, and $19\frac{1}{2}$ on the right. He was ordered to remain quiet in bed, and to take digitalis and laurel water, with morphia at night. On the 13th of June the tumor had increased very much in size; its parietes had become thinner, the breathing was very difficult and accompanied with a loud noise, and he began to be dissatisfied and left the hospital. He dropped dead suddenly while walking in Bow-lane: it was stated that he had thrown up a large quantity of blood. One of our Resident Pupils, Mr. Close, attended the inquest, and made a very accurate examination of the heart and of the aneurismal sac. The arch of the aorta was dilated into a large sac, corresponding in size to the external tumor, and was nearly filled with a laminated coagulum. It had opened into the trachea, just at its bifurcation, by a circular opening the size of sixpence. The cartilages of the ribs and the sternum over the tumor were absorbed; the aneurism had extended downwards from the arch of the aorta, in front of the pericardium, and had pushed the heart back towards the spine. The right pleura was filled with serum; the lung was quite collapsed and filled with purulent spots of broken-down tubercle. The left lung was

* Dubl. Quart. Journal, Med. Science, May 1851.

quite healthy, the heart was rather soft and flaccid, but not otherwise changed. The case was remarkable for the absence of the sounds of the heart over the whole of the thoracic region. When the patient was first admitted it was thought that the pulsating tumor itself might be the heart pushed forwards and to the right, and not, as the *post-mortem* examination showed, the aneurismal tumor which had pushed the heart backwards towards the spine and obscured its sounds.

Case of Dislocation of the Head and Atlas, from Caries and Rupture of the Odontoid and Transverse Ligaments.

Hannah Summers, aged 22, was admitted into Stevens' Hospital, on the 2nd of April, 1857, under Mr. Harrison's care. But little could be learned of her history, except that she had had syphilis, and taken a course of mercury a short time before admission. On coming into hospital she complained of severe pain in the neck, with inability to move the head, and some difficulty in swallowing—the slightest motion of the head giving pain, which was so acute that she constantly lay in her bed on the right side, with the head slightly supported, to prevent its being disturbed. She had perfect use of all her limbs. She was ordered an opium plaster to the back of the neck, and blue pill in alternative doses every night. She continued much in the same state until the 18th, when she began to be kept awake by the pain and nocturnal perspirations. She was ordered quinine and opium, with wine and nourishment.

On the 21st she had a rigor, and the stomach became irritable; ordered the effervescing draught every four hours. On the 25th it was thought that there was a greater amount of pain, and some tension on the left side of the neck, in the situation of the second vertebra, and an incision was made by Mr. Harrison down to the bone from which about half a drachm of pus was discharged. She was much relieved by the incision, which in the course of a few days became converted into a sinus occasionally discharging a drop of thin matter. There was little change in her condition until the 12th of July, which was her birth-day, and she determined on making an effort to get up. On attempting to do so she fainted and remained insensible for about an hour. On recovering, her respiration was slow and difficult, so that she could only speak a word at a time, and it was carried on chiefly by the upper intercostal muscles; all her limbs became paralysed; her pulse was slow and feeble. She continued in that state until the next day at 5 p.m., when she died.

Post-mortem examination, April 14, six, a.m.—The cervical region is congested, and there is preternatural mobility of the head; the left articulation, between the atlas and axis, is carious, and communicates with the fistulous track which remains after the first incision. The capsular ligament

and articular cartilages are quite gone; the odontoid process is also rough, and denuded of periosteum, and the adjacent transverse and alar ligaments are soft and pulpy. The atlas, except at the articulation described, is quite sound. The rupture of the ligaments, and disorganisation of the left atlanto-axoid articulation, had allowed of a partial rotation of the head towards the right side, so as to bring the posterior arch of the atlas towards the odontoid process. The amount of displacement was, of course, very little; indeed, had it been otherwise, she could not have survived the accident for so many hours. The theca vertebralis was not in any way injured; but there was a good deal of bloody serum in the sub-arachnoid space, which I think had been effused subsequently to the injury. Were such a case to occur again I think it might be possible to devise some application of the gutta percha splint, so as to keep the head quite immovable, and allow of ankylosis taking place. Indeed, there is every reason to think that in this case had she remained perfectly stationary, that result might have been obtained.

DISEASE OF THE TESTICLE.

CASE OF CYSTIC TUMOR OF THE SCROTUM.

WITH REMARKS.

By CHRISTOPHER FLEMING, M.D., M.B.L.A.,

Surgeon to the Richmond Hospital.

The following is a case of some interest:—

Patrick Flanagan, aged 9 years, a healthy looking country boy, was brought to the Hospital Dispensary, with a tumor of the scrotum. It occupied the left side, was about the size of a large grape, was uniformly smooth on its surface, had a slightly bluish nævus-like hue, and was perfectly translucent; it lay on the corresponding tunica vaginalis, floated freely over it, and could be raised up from it with the most perfect ease. Its front aspect was identified with the skin of the scrotum. It was free from the slightest pain or uneasiness. The origin of this tumor was traced to a contusion or bruise in riding, about two months previous, yet, at the time, no mark of injury was visible. From its special situation, and gradual increase in size, it created alarm, and ordinary treatment having failed, relief was sought for. Having satisfied myself of the nature of the tumor, I transfixed it with an acupuncture needle; a coffee-coloured fluid escaped, partly externally, and partly subcutaneously, and the fulness subsided; a cooling lotion and gentle compression being directed, the boy was allowed to return home. About six weeks or two months elapsed, when the boy was again brought to hospital. The parents stated that no ill consequences had arisen from the treatment adopted; the swelling disappeared, but after a

time grew up afresh. On examination I found that in appearance and in colour it was much as at first noted, but that its size was much increased, that it now exceeded that of a walnut, and that it had acquired a sort of sacculated or lobulated form, with a feel of much tension. All the other distinctive characters of isolation were the same as before. I admitted the child into hospital, and had a drawing executed by Mr. Conolly, very truthful of the appearances present. Within a few days I passed, crossways, through the tumor, and near its base, a needle armed with a worsted thread, and withdrawing the needle, tied loosely together the extreme ends of the threads, the fluid escaping having the same characters as in the first instance. To describe from day to day the effects of this apparently trifling expedient, would be tedious; suffice it to say, that local inflammation almost instantaneously supervened, accompanied by fever of the worst irritative type; that the removal of the sutures appeared for a time to relieve those symptoms, but that again and again they recurred. The integuments of the scrotum and penis, and of the hypogastric and inguinal regions, put on the characters of the worst possible form of phlegmonoid erysipelas; a succession of comparatively circumscribed patches of suppuration exhibited themselves, requiring surgical interference, and accompanied with sloughing of the subcutaneous cellular tissue and a train of constitutional disturbance of the most alarming character. For more than three weeks this local and general condition continued to excite the greatest apprehensions as to the result of the case. By tonic and stimulant treatment, however, it at length subsided, when, at the end of a month the boy left hospital with every prospect of a permanent cure of his ailment.

Remarks.—Mr. Curling, in the last edition of his valuable work on "Diseases of the Testis," dedicates a chapter to the consideration of the "Cystic Tumor of the Scrotum," and notes it as a very rare form of disease. Indeed it is questionable whether he had himself ever witnessed such, notwithstanding his large experience; and I have, hence, ventured to place on record the above case, which, I am of opinion, constitutes an excellent example of the affection. It is worthy of note, that the case of Mr. Crompton of Birmingham, the particulars of which were furnished to Mr. Curling, occurred in a boy of eight years, when the disease first manifested itself, and that this was an age corresponding with that of the boy under my care. The consideration of the progress of that case induced me to adopt the summary treatment I selected, as I felt satisfied that in the interval between the first and second applications to me, the proliferous character of the cyst was being developed. Cysts of a similar nature are very rare in the scrotum, but along the chord I have not unfrequently met with such, and also at the

upper part of the epididymis. I speak of those which are distinct and detached, and which can almost be rolled under the finger in the loose areolar bed in which they lie. I view them as apart from those forms of encysted hydrocele which occur in this locality. The cause of those tumors it is not easy to divine; yet, the most limited ecchymosis, the result of injury, may tend to form the germ, as would appear in my case. The proper treatment I am not yet fully convinced of. I have acupuncture them, and irritated with the point of the needle the inside of the cyst or cysts; I have treated them by subcutaneous sections; I have tapped and I have injected them. The result of each expedient has been uncertain. Excision I have witnessed under the hands of one of our first surgeons, and death had all but occurred. I cannot be an advocate for the seton, even if only retained for a few hours as in the above case. Again, the very delicate structure of the scrotum, and its peculiarly attenuated condition, as almost necessarily consequent on the growth of such scrotal cyst, must render more than questionable the treatment recommended by Sir B. Brodie, in similar affections of the female breast.

DR. CHURCHILL ON UTERINE POLYPUS.

(Communicated to the Dublin Pathological Society.)

About four years ago, I was sent for to see a servant in a gentleman's family; and who, it was stated, had been dangerously ill; the symptoms were those of uterine hæmorrhage. On examining the vagina I found the cervix and os uteri entirely unaltered, in fact in an almost virgin condition; but on examining further, I thought that the posterior wall was somewhat enlarged. Still, though without any apparent cause, there was a very considerable amount of hæmorrhage; but at this time there was no pain. The woman had been married for some years, but had never had a child; the menstrual discharge had always been normal in quantity until two or three months before I was first called to see her. Upon a careful consideration of the case, I came to the conclusion that there was no variation to be made with regard to the treatment generally adopted in cases of menorrhagia: she was given ergot of rye, cannabis Indica, tannin, gallic acid, &c., but with little or no effect. Sometimes, indeed, she was better for two or three consecutive months, but then the symptoms recurred. She continued in this state until January, 1856, when she was admitted into the Rotundo Hospital by Dr. McClintock. The results of an examination there proved exactly similar to that of the last one which I had made myself; the uterus was enlarged, but the exact nature of the enlargement could not be ascertained; the hæmorrhage (which was occasion-

ally very severe) continued unabated; and now, for the first time, there was complaint of pain. At first it occurred to Dr. M'Clinck, as it had to myself, that there might be an intra-uterine polypus; but on taking into consideration the length of her illness, and that there was none of that expansion of the cervix uteri which is a preliminary to the expulsion of a polypus, we felt very doubtful; a uterine sound was passed, which, although it deviated from its ordinary course, did not make us acquainted with the existence of anything abnormal within the uterus. At length both Dr. M'Clinck and myself came to the conclusion, that in all probability the patient laboured under some malignant disease affecting the interior of the uterus. After some time the patient left the hospital neither better nor worse than when she entered it. Taking the latter view of the case, viz., that it was one of malignant disease of the uterus, it then became a question of some importance whether or not one should venture to inject the cavity with some astringent lotion, and seeing that she was evidently sinking fast under the repeated hæmorrhages, I thought I would give her whatever chance might thereby be afforded, and accordingly injected a strong solution of gallic acid, which gave not the slightest pain; but, on the other hand, was of no service. I then tried a strong solution of the nitrate of silver; this instantly controlled the hæmorrhage, and the operation was several times repeated. The last time it was employed was about four months ago; at that time the cervix and os uteri were in the same state as previously, small, and not distended. About three weeks ago her mistress came to me, saying that for three or four days she had been suffering from the most excruciating pain. I went to the house, prepared to use the injection as before; prior to doing so, however, I introduced my finger into the vagina, and found a large polypus depending by a stalk from the mouth of the uterus. The existence of this tumor satisfactorily explained all the symptoms, and, of course, rendered the prognosis far more favourable than we had at first supposed. I put a ligature round the tumor, and, forty-eight hours afterwards, proceeded to remove the polypus with the knife, but on drawing it downwards for that purpose, it came away, the ligature having severed it completely.

GENEROSITY OF THE AMERICAN EDITOR OF A EUROPEAN WORK.—As a set-off against the wholesale robbery European Medical writers are often subjected to at the hands of their American editors, we may notice the following gratifying fact. When Dr. Draper brought out his edition of Sir Robert Kane's Chemistry, Harper and Brothers paid him 1000 dollars. The whole sum was generously forwarded to Sir Robert Kane by Dr. Draper, who never received any emolument from the work, but was at the trouble of bringing it out because he believed such a work was wanted in the Colleges. The magnanimity of the transaction was enhanced by the fact that Drs. Kane and Draper were strangers to each other, the proceedings being entirely spontaneous on the part of the latter, and unexpected on that of the former.

CASE OF TRUE ANEURISM OF THE ASCENDING AORTA.

By ROBERT LAW, M.D.,

Professor of the Institutes of Medicine, Trinity College, Dublin.

(Communicated to the Dublin Pathological Society.)

The following case of true aneurism of the ascending aorta, from the singular fact of four fatal cases of aneurism of the aorta having occurred to my knowledge within a week, suggests the inquiry whether this is a mere accidental circumstance, or may not be owing to the range of atmospheric influence having more power to modify the cause and results of already existing diseases than is generally supposed? The present case is that of Henry Green, aged sixty, butler in a gentleman's service. He had only entered the service on Wednesday, and died on Friday morning. He had been in the same service two years previously, and on leaving it engaged in another, the duties of which he had been able to fulfil without interruption up to the time of his re-entering the service in which he died. The only complaint he was known to have made at any time was that of a slight pain in the region of the heart, and to this he seemed to attach but little importance. The only change that was observed in his appearance from the time he had been in the service to which he now returned, was what might be attributed to drink, in which he was known to have indulged too freely. Green slept with the coachman on Thursday night, and at six o'clock on Friday morning, when the coachman was getting up, he desired him to send some one to him at seven o'clock with warm water to shave. The cook knocked at his door at seven o'clock. He answered, and said he would remain a little longer in bed. She returned before eight o'clock, knocked at the door, and, receiving no answer, entered his room, and found him dead. A coroner's inquest was held on the body at two o'clock, P.M. The *post-mortem* examination was made by Surgeon Porter and myself. The muscles were very rigid. On raising the sternum a large tumor, almost equal in size to an infant's head, presented itself. It had completely pushed aside the lungs, especially the right. The tumor proved to be an aneurism. In order to make a more complete examination, all the parts were removed. There was no effusion of blood into either pleura or pericardium. The tumor contained grumous blood, but no coagula. It engaged all the ascending portion of the aorta, but involved neither the semilunar valves nor the arteria innominate; all the right side of the artery between these two points was dilated into a pouch, which sank into the right side of the chest, compressing the lung of this side. It exercised no pressure on the trachea. All the coats of the aorta formed the walls of the tumor. Its internal surface was rough,

with bony and extensive atheromatous deposits, which also extended for some way into the descending aorta. The semilunar valves were quite healthy. The right ventricle of the heart was soft, flabby, and loaded with fat. The left was firm and contracted, and was filled with coagulated blood.

The chief points of interest connected with the case are: That a man with such a disease should be able to discharge the duties of an active service to within so short time before death. It also tends to show how entirely the diagnosis of aneurism of the thoracic aorta depends on the phenomena resulting from the pressure of the tumor on the organs situated in its vicinity, and how little inconvenience results to the patient from this formidable disease when the tumor exercises no such pressure, as well as how obscure are the indications of its existence to the physician under such circumstances. I do not think that sufficient attention has been paid to the anatomical relations of the different portions of the aorta to the surrounding organs, and from which relations the diagnostic phenomena of this disease result. Thus the phenomenon of dysphagia is often looked for when the aneurism engages the ascending or transverse portion of the artery, while in the former instance, as exemplified in the present case, the aneurism does not approach the œsophagus; and in the latter it must first compress the trachea, and that forcibly, before it can affect the œsophagus. In the same way the stridulous breathing is often expected when the aneurism engages the descending aorta, whereas this can only result from the pressure being first exercised on the œsophagus, and through it on the trachea.

This case is also remarkable from the fact of death having occurred without the aneurism having given way. I believe this was the effect of syncope, the large quantity of blood in the tumor being almost equivalent to the same amount of loss from hæmorrhage; the contracted condition of the left ventricle very much resembled the state in which it is very generally found when hæmorrhage has preceded or caused death.

DUBLIN STATISTICAL SOCIETY.

OUR HOSPITAL SYSTEM COMPARED WITH THOSE OF ENGLAND, FRANCE, AND AUSTRIA.

On the evening of Monday, June 15th, at a meeting of the above society, held in the Royal Dublin Society House, a paper, entitled "Our Hospital System compared with those of England, France, and Austria," was read by ROBERT M'DONNELL, M.D., M.R.I.A.

Dr. M'Donnell entered into very full details regarding the accommodation, management, and economy of our institutions for the relief of the sick poor, not only in Dublin, but generally throughout Ireland; and after presenting such a

general review of the hospital systems of London, Paris, and Vienna, as was sufficient for the purpose of comparison, concluded his paper in words to the following effect:—

"We find, then, that while

In Dublin there is 1 hospital bed for every 208 inhabitants, the annual expense of a bed being about £24, as in Steevens' hospital,
In London there is 1 bed for every 528 inhabitants, costing annually £50, as in St. Bartholomew's,
In Vienna there is 1 bed for every 124 inhabitants, costing annually £14, in the General Hospital,
In Paris there is 1 bed for every 150 inhabitants, costing annually £27, as in the Hotel Dieu.

We also find that while in London the hospitals depend chiefly for support on voluntary contributions, a totally different scheme, bearing particularly hard on the sick poor, is adopted in Vienna, while in Dublin, as in Paris, the income of the hospitals arises partly from private charity, partly from taxation either local or general, and to some small extent, from paying patients.

Whether or not it may be the duty of a well-governed state to provide for the succour and relief of the sick poor, is a question on which I do not enter. It may be assumed that the very existence of many of the charitable institutions met with in all civilized countries practically acknowledges the truth of this principle.

In endeavouring to ascertain the best mode of hospital administration, some useful hints may be derived from the systems prevalent in London, Paris, and Vienna; and on this ground I hope I shall be excused from having gone, perhaps, at too great length, into a review of their systems.

A recent writer observes that "there are many phrases cherished by the nation, and inscribed by it on flags of triumph, which are not so really glorious as the inscription commonly seen running across the walls of a great hospital—'Supported by voluntary contributions.' How large a mass of quiet charity, exerted year by year, keeps every such establishment in action!"

This is no doubt very true. It is a fine, it is a glorious thing, to see a great effort made to succour and assist the sick and suffering. It is a feeling to be cherished in every Christian community. But is it certain that the principle of voluntary hospitals is free from grave objections? Alas! by no means. In practice the voluntary system is found altogether insufficient to meet the wants it is intended to supply. It becomes absurd as well as cruel to leave this duty to the precarious charity of private individuals. Look at London; see how inadequately the voluntary system supplies this wealthy metropolis with hospital accommodation. Turn to the reports of the various hospitals in the large cities of these islands, and see whether those supported by voluntary contributions are truly able to meet the exigencies of their respective localities. Let me read a sentence from a late report of the general

hospital of our most flourishing Irish town (Belfast):—"It is deeply to be regretted that this, the most generally useful, the most urgently required, and the only one, of all the public institutions in Belfast, depending on voluntary contributions, should have suspended its operations, and closed its doors against that class who, of all others, most deserve our sympathy, and most need our assistance; against those who have been smitten with two of the greatest evils that afflict humanity—poverty and disease."

That this should have occurred in a town inferior to none in the United Kingdom, in proportion to its extent, in wealth, public spirit, and liberality, at least shows that there are weighty objections to an exclusively voluntary system of hospital support.

We can in some degree excuse, although we cannot quite agree with, a cotemporary who, in his disgust at the voluntary system, as worked in London, exclaims:—"Who would not feel a relief at the cessation, at once and for ever, at least as far as hospitals are concerned, of the ludicrous hypocrisy of charity dinners, where we contract an indigestion on indifferent fare and bad wine; of charity balls, where we dance and flirt; of charity concerts, where we are wearied with indifferent music; of charity bazaars, where we are wheedled into buying useless trash, by charming and aristocratic young ladies, who condescend to cheat and rob us, all in the sacred name of charity."

Admitting that many and solid arguments may be adduced in favor of the voluntary system, yet even as met with in London, where it cannot be said to exist exclusively, it is to be objected to—1st, on economic grounds, as an extravagant mode of obtaining the necessary funds. 2nd, as being precarious and uncertain. And 3rd, as being insufficient to meet the desired end.

Although, therefore, it is to be presumed that no one could be found in this country who would be mad enough to advocate any such scheme as we have seen to be adopted in Vienna, of actually prohibiting the exercise of the noblest of Christian virtues; although, on the contrary, all will agree that private benevolence, shown in support of institutions for the sick, is to be, by every means, encouraged, yet some auxiliary means must be adopted for this purpose, more certain than mere individual beneficence.

The county infirmaries throughout Ireland are, it is true, in some degree supported by private charity, but by much the largest portion of their income is derived from local taxation, and this is, no doubt, the true principle of support for such hospitals; but it is obvious from what has been already said, that a county is too large an area to be assessed for the support of an establishment which, no matter how well placed, must be out of reach of the mass. For the sick poor have no ambulances or sedans, to bear them over many

miles of country to an hospital. Neither can it be expected that the gentry of a large county will continue patiently to pay county cess, in support of an infirmary so remote, that no labourer or farm servant of theirs can, in illness, be benefited by it. Justice to those who contribute to the hospital, whether voluntarily or by taxation, as well as humanity towards those who require its use, demand that a much smaller area than a county should be fixed upon.

The hospitals of a metropolis, and those in large cities in which medical schools exist, stand on a different basis from those diffused throughout country districts. They should be (and are in Dublin, as elsewhere) largely aided by private charity. The principle of support by local taxation does not, nor indeed should it, come so much to their assistance; for metropolitan hospitals not only receive patients from all parts of the kingdom, but, as places of medical education, they confer benefits on the community far beyond the walls of the cities in which they exist. On this ground, hospitals which are used for educational purposes receive support from the state.

One word in conclusion, as to the plan of allowing part of the expense, while in hospital, to fall on the patient or his family. This is a great principle, as yet undeveloped in this country. M. de Watteville, in his admirable report on the French charities, already alluded to, tells us that in France an annual income of 1,817,967 francs is derived from this source. "Not only," he says, "is the creation of paying beds in the hospitals useful to these establishments, but it is eminently useful to the working classes."

But it is not under the supposition that any considerable sum could be realized in this way, that the plan seems worthy of the warmest advocacy; it is because of its moral influence; it is because the industrious poor man may be received into the same hospital, and treated alongside a pauper, yet this feeling that he is doing something towards his own support, causes him not to hang his head for honest poverty. Though it were but a penny a-week, it is enough to fix a great gulf between the poor man and the pauper.

The inauguration of the statue of the celebrated anatomist and physiologist, Bichat, took place in Paris on July 17th, with great *éclat*. The Minister of Public Instruction presided; and speeches, eulogistic of the life and labours of Bichat, were delivered by the President, by M. Amedée Latour, Baron Larry, M. Serres, and M. Paul Dubois. The statue, which is in bronze, is the work of the celebrated sculptor David. Bichat is represented, in the costume of the time of the consulate, standing in an attitude of meditation. His arms are folded across his chest. The right hand holds a pen; from the left falls a roll, on which are written the names of his great works—*De la Vie et de la Mort*, and *Anatomie Générale*. At his feet, and behind, lies, half covered, a subject prepared for dissection. The pedestal of marble on which the statue rests bears the following simple inscription:—"A Xavier Bichat: le Congrès Médical de France de 1845."

EMBOLIC APOPLEXY, CAUSED BY A FIBRINOUS CONCRETION, DETACHED FROM A CAROTID ANEURISM.

By Dr. Fr. ESMARCH,

Director of the Surgical "Klinik" in Kiel.

"Virchow's" Archiv für pathologische Anatomie und Physiologie und für Klinische Medicin. 1857. Heft 5.

Dr. Esmarch, before proceeding to give an account of the case of Embolic Apoplexy, glances at the history of Emboli, and refers to the labours of Virchow and others on this subject, interesting alike to the pathologist and the practical physician. Since Virchow, in his work on acute inflammation of the arteries (1st vol. Archiv.) established the fact that blood-vessels may be suddenly obstructed by plugs brought from distant parts of the circulating system, many additional observations have been made by himself and others.

In the work referred to, Virchow gave four examples, in which Emboli obstructing vessels in the brain, induced symptoms of apoplexy, and gave rise to softening of that part of the brain from which the arterial supply was cut off. Rühle, Kirkes, Traube, and others have contributed facts, and thrown additional light upon this subject. Virchow has lately (Archiv. Band 9, 1856) shown that the hæmorrhagic inflammation of the spleen, the kidneys, and the eye, are connected with Emboli; and thus, he says, as we have to distinguish the Apoplexia Embolica from the Apoplexia Sanguinea, so must we in future look upon some of the cases of pyæmic and uræmic amaurosis as Embolic.

Dr. Esmarch considers the case which he contributes as one not without interest, as regards its etiology and diagnosis; and he believes it to be one of the first, the nature of which was determined with great certainty during the life of the patient. Before we give a resumé of Dr. Esmarch's paper, we would refer the reader to the August No., 1856, of the *Dublin Quarterly Journal*, for a communication of great value on the subject of Emboli, from the pen of Professor Gustav von Düben, and to the DUBLIN HOSPITAL GAZETTE, vol. iii., p. 143, for a very valuable case by Professor Schützenberger, of Strasburg, and to the same volume, pages 248, 260, for an admirable paper on the subject, from the Danish Hospital Reports, by Dr. Brünnicke.

The subject of Dr. Esmarch's case was a captain of a ship, aged 37; he was a strong man, and had led a moderate life, and never suffered from any severe disease. On the voyage from Gothland to Kiel he was attacked with angina tonsillaris. When he applied for advice (1st May), a swelling at the right side of his neck was observed, which had existed about three years, and which had gradually attained its present size. It occupied the trigonum colli superius of the left side, and was of the size of a hen's egg; pressure had the effect of diminishing it to some ex-

tent, and a sensation of a whirring pulsation was communicated to the hand. The physician who first saw the case came to the conclusion that there existed aneurism of the left common carotid artery, but expressed no opinion, and determined on another examination, and then to communicate to the patient the dangerous nature of the disease, from which he could only be relieved by operative interference.

On the 8th of May the case was again investigated, and on endeavouring, by gradually augmented pressure, to reduce the size of the tumor, the man suddenly fell back, presenting the usual symptoms of apoplexy. Venesection to 16 ozs. was immediately performed, after which Dr. Esmarch saw the patient for the first time. He was a portly man, with a short thick neck; his pulse was moderately full, soft, and very slow (58 in a minute). Auscultation of the heart revealed no abnormal sound. He was not perfectly deprived of consciousness, but he lay, as it were, in a profound sleep; however, on being addressed in his mother tongue, he opened his eyes, and turned them towards the person who spoke to him, answering slowly but correctly; soon, however, the words were unconnected, and finally he became perfectly speechless. The right side of the body and the face were paralysed; the right eye was half open; the left shut; but it was, from time to time, quickly opened; the pupils were of a moderate size, and were equally influenced by light. The muscles of the right side of the face were perfectly paralysed, consequently, the face was drawn somewhat to the left. On expiration, the right cheek was mechanically puffed out. The muscles of the left side of the face contracted sometimes convulsively, dragging the left angle of the mouth towards the eye. The face was moderately red; the head was not hot; the mucous membrane of the mouth, probably in consequence of the bleeding, presented an anæmic appearance. The point of the tongue, which was heavily loaded, was directed towards the left; its body somewhat to the right. The respiration was slow and deep, with the peculiar sound which depends upon paralysis of the velum palati. The motions of the respiratory muscles of the chest were normal and uniform at both sides; the muscles of the abdomen, on the left side only, contracted from time to time so that a deep furrow was visible between the obliquus superior and the upper part of the rectus abdominis. Both extremities of the right side were completely paralysed, but the temperature and the pulse were the same as the left side, which was constantly in motion; but still the movements did not appear to be objectless; frequently he raised the arm, which was marked with blood, towards his eye, as if to examine it; again, he endeavoured to cover the genitals with his shirt or the bed-clothes, and resisted the arrangement of the bandage on his arm; deglutition, defecation, and the secretion of urine, were naturally performed.

On the left side of the neck, in the trigonum superius, was an elastic roundish tumor, the middle of which corresponded, pretty nearly, with the ligamentum crico-thyroideum; it was covered by healthy integument skin, and was of the size of a large pigeon's egg, and, according to the opinion of the physician, it had become smaller since the apoplectic seizure than it had been previously. It was found by palpation that over the whole tumor a pulsation was present, which was synchronous with the carotid pulse of the opposite side. The pulse of the left temporal artery of the left side was synchronous with that of the right; no bellows murmur was audible in the tumor, and it was not considered, under existing circumstances, safe to try whether gradual pressure would have the effect of reducing its size.

The whole course of the case led Dr. E. to the opinion that the left cerebral carotid artery was plugged up by a fibrinous concretion, which had been detached from the aneurism by the examination. The possibility of the apoplectic symptoms being caused by the rupture of a vessel, and consequent extravasation of blood into the substance of the brain was not lost sight of, as the same atheromatous condition which the presence of the aneurism proclaimed, might exist in the small arteries of the brain. The opinion, however, was in favour of Emboli, guided by the circumstances of the paralysis, &c., and the observations of Virchow (*Pathologie* i. p. 175).

Now, as regards the treatment, plans have been recommended which are diametrically opposite. Traube (*Deutsche Klinik*, 1854, p. 500) has advised, instead of antiphlogistics, stimulating and strengthening remedies; the object being to increase the pressure on the arterial system, and thus expedite the establishment of the collateral circulation. Dr. Esmarch, however, rather agrees with Virchow in the opinion that the active hyperæmia is a condition of danger, and, in the present case, the stimulating plan was to be feared, owing to the probably diseased condition of the arterial walls, and the likelihood of adding sanguineous to embolic apoplexy. The symptoms, then, justified the abstraction of blood; in addition, ice was applied to the head, sinapisms to the calves of the legs, and an enema of vinegar administered. The bowels acted copiously, and urine passed at the same time. The following night he slept, but at times he was very restless. He passed urine frequently, and made signs when he required the chamber utensil. He drank cold water many times, giving notice, by smacking his lips, of his wish for it. The next day brought an evident improvement; the sensorium was more free; he recognised a countryman who visited him, and he spoke correctly to him; but the speaking was a matter of difficulty. The snoring respiration had ceased. The pulse was 60. The paralytic symptoms remained unaltered, so far as the extremities of the right side were concerned; but the right half of the face was improved; both

eyes could be perfectly closed; but the right more slowly than the left. On being asked if he had headache, he answered in the negative; but he moved his head frequently about, and evinced a dislike to the cold application, which was accordingly removed.

The following night was passed in almost perfect quiet, and in the morning (May 10th) the mind was more clear; he did what he was asked; for example, he put out his tongue quickly, and it was straight. He answered correctly. In the afternoon delirium set in, which alternated with coma. The colour of the face was rather red; the temperature of the head was natural; the body and the extremities were cool; the pulse was irregular, and fluctuated between 64 and 88. An enema with four drops of croton oil was given, which produced a thin, but not copious evacuation. During the night he was very restless. In the morning (11th May) he fell into a state of profound coma, from which he could not be roused by calling to him. The pulse was very frequent; the skin cool; the colour of the face blue; the urine passed involuntarily. Twelve leeches were applied to the left temple; sinapisms to the calves of the legs; heat to the feet; enemata were administered, but without effect. In the evening the face became more cyanotic; the pulse incalculably rapid; and the respiration very slow. The patient died at midnight.

The necroscopic examination, which was made at noon next day, fully confirmed the diagnosis. On removing the coverings it was found that the common carotid formed the aneurism, which was spindle-shaped. The whole artery up to its division and the aneurism were laid open. The inner coat of the vessel, from its origin up to the aneurism, was in a state of atheromatous degeneration, with plates of bony and chalky deposit. The interior of the sac was in part lined with a smooth brownish red membrane, and there were numerous shaggy coagula entangled with each other in all directions, filling the sac; the coagula were of different colours. On slitting up the internal carotid, a thin spiral coagulum appeared, which was drawn out, and broke off about the carotid canal, the point of separation of which was afterwards found to correspond accurately with the coagulum found in the intra-cranial carotid. The external carotid did not contain a coagulum. On opening the cranium, the vessels of the pia mater were found in a state of hyperæmia; there was a moderate amount of serum beneath the arachnoid; the convolutions of the left hemisphere were less elevated than those of the right. The entire of the middle parts of the left hemisphere, viz., the optic thalamus, the corpus striatum, and part of the corpus callosum, were in a state of extreme softening, and of a yellowish grey colour. The portions of the brain adjoining, and which were not softened, presented, on section, larger and more numerous vascular points than the normal brain substance of the right hemisphere. Both lateral ventricles contained a considerable quantity

of clear serum. At the lower end of the aqueduct of Sylvius, in the middle line of the pons varolii, there was a perfectly recent blood extravasation, of the size of a bean, and in front, and about four lines distant, was a second similar but smaller one; in the vicinity of both there were many little capillary extravasations. The microscope proved that the softened tissue did not retain a trace of the appearance of normal brain; it consisted of free granules and of short broken-down brain fibres, and between were capillary vessels, in which the blood corpuscles were partly shrivelled and rolled up in little masses; in the walls of the capillaries were some fat granules. The blood globules in the extravasation at the pons varolii were quite unchanged. The cerebral carotid was perfectly plugged up with a firm coagulum, the lower part of which, as before mentioned, corresponded with that which had been drawn out of the internal carotid; the same filled the arteria fossæ Sylvii, to its finest twigs, and also the arteria opthalmica to its exit from the foramen. This coagulum was of a dark red colour, but it contained in many parts bright red fragments, and some also of a grey hue, of irregular forms and of different sizes, which clearly had their origin in the aneurism, with the coagula of which they accurately corresponded, both in colour and histological constitution. The pericardium contained very little serum. The heart was of normal size, and on its surface fat in considerable quantity existed; the valves were thickened and uneven from atheromatous deposit, but not to such an extent as to render them insufficient. The ascending aorta was the seat of considerable atheromatous degeneration, and there were also numerous calcareous plates of large size, but at no part were they loose or crumbling. The examination of other parts of the body did not reveal anything worthy of notice.

The details of the dissection leave no doubt of the accuracy of the opinion as to the nature of the disease; the identity of the coagulum which formed the plug with the contents of the aneurism was established. The collateral hyperæmia justified the line of treatment pursued. It is also very probable that the sudden exacerbation of the symptoms was caused by the effusion of blood into parts of the brain of such importance, and it may be, that this might have been prevented by a repetition of the blood-letting. The author, with Dr. Jessen, has published a case in the *Allgemeine Zeitschrift für Psychiatrie*, which he says deserves to be mentioned here, as it shows that Embolic Apoplexy may terminate favourably under antiphlogistic treatment.

On examination of the brain of a man who had an apoplectic seizure, six years before his death, and who had recovered from the attack, under antiphlogistic treatment, it was found that in the optic thalamus there existed softening, and the corresponding artery was completely plugged up

by a coagulum. The degeneration of the brain was of long standing, and he had laboured under paralytic symptoms. The extent of cerebral disease in this case was by no means so great as in that of the case under consideration.

The author states that he has not been able to find any case of apoplexy recorded in connexion with carotid aneurism; but the facts of his case will, no doubt, serve as a warning in examinations made under similar circumstances.

Reference is made to two cases of subclavian aneurism, published in the *Lancet*, (Sep. 1855,) in which Mr. Ferguson, by pressure on the tumor, forced coagula into the axillary and brachial arteries. Although Mr. F. recommends pressure to be employed in certain cases of aneurism, he, at the same time, enjoins caution, lest more injury than benefit result. That pressure in carotid aneurism is inapplicable, the history of the above case amply proves.

Dr. Esmarch concludes his most valuable contribution to our knowledge on the subject of Emboli by reference to a case which, he thinks, may be fairly considered worthy of notice in connexion with the case he has detailed:—

In an action which was fought during the Germanico-Danish war, a soldier was shot through the arm, and the wound was probably followed by profuse hæmorrhage; a field tourniquet was placed on the arm very firmly. During the transport of the wounded, which lasted many hours, the arm became so swollen that when the man arrived at the hospital, at Christiansfeld, the strap of the tourniquet lay buried in a deep furrow. On the surgeon removing the tourniquet the patient instantly fell to the ground, lifeless. To Dr. Esmarch it appears likely that the man's death was caused by coagula, formed in the veins of the arm, being carried to the right side of the heart (on the removal of the ligature), and thence to the lungs. Unfortunately, an examination of the body could not be made, the living affording abundant occupation to the medical officers.

That sudden deaths may be caused by Emboli has been proved (*Virchow*) by experiments and pathological observations.

PLASTIC OPERATIONS FOR THE RELIEF OF DEFORMITIES OF FACE AND NECK.

Mr. Teale, of the Leeds Infirmary, relates in the *Medical Times and Gazette* for June 6th, 13th, and 20th, several cases in which he has performed plastic operations, for the restoration of parts after extensive burns of the face and neck, with great success. In some of these cases, not only was the chin drawn down to the sternum by the cicatrix, but the lower lip was completely everted, allowing the saliva to dribble continually from the mouth. For this deformity he performed the following operation:—

"Two vertical incisions, about three-quarters of an inch in extent, are made through the everted lip, down to the bone. These incisions are so placed as to divide the upper portion of the everted lip into three parts—the middle being equal to one-half of the natural breadth of the lip, while the two lateral portions are each equal to one-fourth. From the lower end of each vertical incision the knife is carried in a curving direction outwards and upwards, to a point situated about one inch from the angle of the mouth, opposite to the second molar tooth of the upper jaw. The two flaps thus marked out and deeply incised are then separated from the bone, the mucous membrane uniting them to the alveoli being freely divided. Lastly, a bare surface is made along the alveolar border of the middle portion of the everted lip. The incisions being now completed, the lateral flaps are drawn upwards and united by twisted sutures to each other in the median line, and to the middle portion of the everted lip at their inferior border. In this way a new lip is, as it were, built upon the middle portion of the old one."

During the process of cicatrization the upper lip is sometimes drawn out of its place, exposing the teeth in a very unseemly manner. In such a case Mr. Teale recommends the following procedure:—

"A crucial incision is made (*en saltire*), having its point of intersection immediately below the septum of the nose. Each limb of this incision is about one-and-a-half inch in length. The two limbs on each side diverge moderately as they pass outwards to the cheek, and enclose between them an acutely angular flap of skin and other tissues. This crucial incision is extended deeply through the entire substance of the imperfect lip and the cheeks. The parts implicated in the incisions are then freely loosed from their attachments to the superior maxillary bone by the knife being passed upwards between the bone and the remnant of lip. The parts being thus detached, the two lateral angular flaps are drawn across the median line, dovetailing with each other, and thereby increasing the depth of the lip at the expense of its breadth. In this position the flaps are retained by one pin and twisted suture."

Mr. Teale's plan of operating for contractions of the neck is that first employed by Mr. Carden of Worcester, and afterwards very successfully by Professors Mütter and Pancoart of Philadelphia, viz., of transplanting a flap from the side of the neck or shoulder into the gap left after the division of the cicatrix. The very great degree of success which has attended this mode of operating in Mr. Teale's hands recommends it still further to the profession. He makes the following remarks concerning it:—

"I have performed this operation in seven cases since August, 1848, and have witnessed it in some others by my colleagues at the Leeds Infirmary.

In all the cases which I have seen there was

a marked and most satisfactory improvement in the movements of the head and neck. The displacement of the lip was also in a greater or less degree mitigated by the operation on the neck, but in several of the cases this particular deformity remained to such an extent as to render a special operation for the restoration of the lower lip subsequently necessary.

In these autoplasmic operations on the neck it is of essential importance, as stated by Dr. Mütter, that the incision of the scar should extend from sound skin on one side of it to sound skin on the other, and that every band of adventitious fibrous tissue beneath the scar should be divided until the bottom of the wound discloses a loose healthy cellular tissue.

The flap to be transplanted may be taken from any neighbouring portion of the neck, shoulder, or thorax, where healthy skin can be obtained. In one case, from lack of sufficient sound skin, I was under the necessity of including cicatrised skin in the flap.

The very accurate adaptation of the flap by suture should be avoided, as great tension renders the flap liable to slough. It is therefore better to be content with attaching the flap at its free extremity and one of its borders, and to leave the other border loose. Much may be done afterwards by careful dressing, during the healing process, to rectify any separation of the parts.

As far as I have observed, the transplanted flap rarely unites to the edges of the wound by the 'first intention.' All that is usually accomplished in the first instance is an organic union of the cellular surface of the flap to the parts beneath. The more close approximation of the edges of skin is obtained during the processes of granulation and healing.

When the bands of scar are so numerous or extensive as to require more flaps of skin than one to be inserted, it is better to repeat the operation at separate times. I saw much constitutional disturbance in one case from the operation having been conducted on too large a scale in the first instance.

After the lapse of some months the transplanted portion of skin is generally found to have yielded to a process of stretching, so as to exceed considerably its original dimensions."

EAST INDIA EXAMINATION QUESTIONS.

The following questions were put at the late examination for Assistant-Surgeons in the East India Company's Service. This examination occupied two days; and on the following days candidates were examined orally, and were also called on to examine patients, and to perform operations on the dead subject. Only fifteen appointments were vacant, and for these forty-one gentlemen contended.

ANATOMY AND PHYSIOLOGY.—MR. BUSE.

1. Describe the shoulder-joint, enumerating in their order the muscles surrounding it, and noticing the mode in which the various movements of the joint are effected by them.
2. Describe the surgical anatomy of the external iliac artery, and the operation for the ligature of the vessel.
3. Describe the parts exposed by the entire removal of the pectoralis major muscle.
4. Describe the parts concerned in the different kinds of inguinal hernia, and the distinctive anatomical characters of each.
5. Describe the blood in man, including its physical and chemical characters; and noticing the distinctive peculiarities of the blood in man, and other mammals, birds, fish, and reptiles.
6. Describe the structure of the permanent cartilaginous tissues in the human body, noticing the parts in which they occur, and the uses to which they are subservient.
7. Describe the processes of digestion and absorption of bread, meat, and milk.

NATURAL HISTORY.—DR. HOOKER.

Answer five or more of the following Questions.

1. Give examples of plants having esculent or medicinal subterranean stems, and describe shortly the nature of their stems.
2. Describe the flowers and fruits of wheat, oats, and barley.
3. What are the characters of the flowers of *Orchidea*, *Iridea*, *Labiata*, *Composita*, and *Leguminosa*? Give examples of each order.
4. How does the woody root of a Dicotyledonous plant differ from the stem of the same?
5. What plants produce galbanum, sagapenum, myrrh, aloes, and cloves?—what are these products, and what countries do they come from?
6. What natural orders or species of plants abound most in oxalic, malic, and prussic acids?—what are the properties of those acids?—how may they be recognised, and what are the antidotes for poisoning by any of them?
7. In what respect as articles of diet do wheat-flour, pea-flour, Cruciferous and Umbelliferous vegetables differ from one another?
8. What does the process of assimilation in plants consist of?
9. What are the usual products of decomposition of animal matter, and what of vegetable?
10. How would you distinguish a cotton from a linen fabric?—what are their respective properties as articles of clothing?
11. What are woody-fibre, spiral vessels, cork, and bast?
12. What parts of what plants are usually employed in making common thread, rope, and cotton-thread?
13. What are the differences between boiled and un-boiled water; and between hard and soft water? and how may hard water be rendered soft?
14. What are land and sea-breezes? what are the causes of them, and what their general effects in hot climates?
15. If required to find the best site for a permanent station on a damp tropical coast, to what local circumstances in the soil, climate, &c., would you direct your attention?

Answer two or more of the following Questions.

1. How do the teeth of Rodents, Ruminants, and Carnivora differ; and what modifications of food do these differences indicate?
2. Describe in general terms the eyes in Mammalia, Reptilia, Aves, Insecta, and Cephalopoda.
3. To what classes of animals do the *Teredo Navalis*,

Guinea-worm, Leech, Water-newt, and Tapeworm belong? Give short characters of any or all of these animals, and of their habits.

4. Define the terms Morphology, Comparative Anatomy, Histology, Psychology, class, order, genus, and species.

5. Write down the scientific name of a Mammal, Bird, Insect and Fish, together with the names of the classes, orders and divisions of the Animal Kingdom to which they severally belong.

MEDICINE.—DR. PARKES.

1. What are the causes, symptoms, and treatment of paralysis of the Portio dura?
2. Describe the general and microscopic characters of the several forms of softening the brain.
3. Give the causes, anatomical characters, symptoms, and effects of vesicular emphysema of the lungs.
4. What are the chief causes of hypertrophy of the left ventricle of the heart? What are the physical signs of such hypertrophy, and of the most usual coincident cardiac lesions?
5. How would you tell that a liver is enlarged? Give the diagnosis of the several kinds of enlargement or tumor of the liver?
6. Enumerate the causes of hæmatemesis and melæna? Prescribe for a case of hæmatemesis supposed to depend on simple ulcer of the stomach, and write the prescriptions in full.
7. What are the symptoms, causes, and treatment of rickets in children?
8. What are the causes and treatment of puerperal convulsions?
9. A man, aged 36, supposed to be in good health, was employed in the month of November in work which obliged him to stand in water to his waist. In three or four days he noticed that his legs were swollen, and on the following day he had violent pain in the head, dry cough, and difficult respiration. When first seen, nine days later, there was general anasarca, excessive headache, dry tongue, albuminous urine, and general dry bronchitis. These symptoms continued for some days, and were then attended by palpitation, enfeebled vision, increased cough, viscid reddish expectoration, crepitant râle, and then bronchial respiration at the apex of the right lung. On the following day there was delirium, and almost complete suppression of urine, and in a few hours afterwards coma and death.
- State generally what was the course of events from the period of attack till death; describe fully the condition of the urine during the case, and the condition of the kidneys and lungs after death. State what nosological term you would have applied to such a disease, and what treatment you would have adopted.
10. What modifications in the quality and quantity of food would you recommend for adult Europeans, who are suddenly transferred from a temperate to a tropical climate?

SURGERY.—MR. PAGET.

1. Describe and explain the symptoms of complete paralysis of one of the 3rd, or oculo-motor, pair of nerves.
2. Give some account of rigors or shivering-fits occurring after surgical operations, stating what they may indicate according to the times and manners of their occurrences.
3. Describe the usual characters of dry gangrene, as it occurs in the lower extremities; enumerate the chief causes of it; describe the process of separation of the gangrenous part; and if there be any cases of the kind in which you would amputate a limb above the line of demarcation, state what they are.
4. Give an account of urinary perineal fistula: stating, particularly, the chief causes and manners of their formation, and the appropriate modes of treatment.
5. Describe the process of cicatrization, as it may

be seen after the separation of the eschar of a burn extending deep into the subcutaneous tissue: describe also the contraction of scars, formed after such burns, and briefly, the best means of preventing it.

6. State the symptoms of dislocation of the head of the humerus into the axilla; indicating, particularly, those among them which are most trustworthy in diagnosis.

7. Write prescriptions in Latin for what are or may be used in hospital practice, as lead-wash, spirit-wash, zinc-wash, black-wash, alum-gargle, black draught, jalap and calomel pills, colocynth and calomel pills, and morphia draught.

8. A girl, 10 years old, cut her wrist three days before her admission into an hospital, with a piece of a broken jug, which entered just to the inner side of the median line of the wrist, on its palmar aspect. The wound, it was stated, bled severely at the time of infliction, and was immediately padded and bandaged. No further bleeding ensued; but, when she was admitted, the wound was not healed, but contained a clot of blood, and was near the highest part of a pulsating swelling, which extended down to the palm. The radial artery in its whole length, and all the digital arteries, pulsated naturally; the ulnar artery pulsated as far as the swelling, into or beneath which it seemed to pass. Pressure on the radial artery at or above the wrist stopped the pulsation in the swelling; pressure on the ulnar did not affect it.

State what you think had happened in this case, and how you would have treated it.

LIST OF SUCCESSFUL CANDIDATES, arranged in the order of merit.—1. William Playfair, M.D. Ed., M.R.C.S. Ed. 2. Hugh Clark, M.D., M.R.C.S. Ed. 3. George Sutherland, L.R.C.S. Ed. 4. William R. Grylls, M.D. St. And., M.R.C.S.E. 5. Wm. E. Caird, M.R.C.S.E. 6. Richard Banbury, M.R.C.S.E. 7. James Brenner, M.D., Aber., M.R.C.S. Ed. 8. Emanuel Bonaira, M.D., Malta, M.R.C.S.E. 9. Albert A. Mott, M.R.C.S.E. 10. Adam Taylor, M.R.C.S.E. 11. James T. J. Doyle, M.R.C.S. Ir. 12. Lindsay F. Dickson, M.D. St. And., M.R.C.S.E. 13. Denis B. Daly, M.D. St. And., M.R.C.S.E. & I. 14. Andrew N. E. Riddell, M.R.C.S.E. 15. Alfred Marshall, M.R.C.S.E.

Bibliography.

Asylum Journal of Mental Science. Vol. iii. No. 22, July).

The present number contains much valuable and interesting matter; its perusal has afforded us much pleasure. Among the original articles the first is from the pen of Dr. Noble, on certain residual prejudices of the convalescent and recovered insane, and will be found worthy of a careful and attentive perusal. The next paper contains the concluding portion of Dr. Tuke's treatise on the various forms of mental disorder, being the substance of lectures delivered at the York School of Medicine; the subjects of this paper are, mania in general, and puerperal insanity. Third—annual reports of county lunatic asylums and hospitals of the insane in England and Wales, published during the year 1856. This presents, in the form of a review, a digest of twenty-seven hospital and asylum reports, with a

careful and elaborate *resumé* of the principal matters of interest (and they are many) contained in these documents, extending to upwards of 40 pages, by the editor. Fourth—on the terms Delusion, Illusion, and Hallucination, by Dr. Blount, Part II. The object of this paper is to point out where and why certain phenomena which are now most universally confused and confounded, at least as far as language is concerned, should be rendered distinct and determinate, both in name and category. The distinctive features of those faculties, whose morbid phenomena are designated by the above three terms, are here clearly and ably defined. In the review department will be found a most interesting *critique* on Chesterton's "Revelations of Prison Life;" also, the first part of analysis of the Commissioners' Report on the state of lunatic asylums, and of the law relating to lunacy in Scotland. Upon the disclosures contained in their great Blue Book, full of painful interest as they are, we shall not at present dwell. In fine, we should not omit to notice the report of the medical evidence in the case of Mr. Snape, a case which for a time excited considerable effervescence in the public mind.

Thirteenth Annual Report of the Directors of James Murray's Royal Asylum for Lunatics, near Perth. 1857.

In addition to the usual record of the past year's proceedings, we find here some excellent practical reflections and suggestions by the medical superintendent. We would particularise as deserving of notice, his remarks on the hitherto imperfectly handled topic of the effects of tobacco—its use and abuse; also, on the mischievous results accruing to the moral health of the community from illustrated criminal reports and such loathsome literature. The recent establishment of an asylum periodical, as a medium for the publication of the literary lucubrations of the inmates, is a remarkable and interesting feature in the history of the above institution.

Annual Report of the Royal Edinburgh Asylum for the Insane, for the year 1856.

We have here an interesting record of continued prosperity and success, notwithstanding that difficulties of an anxious and embarrassing kind appear to have been encountered during the past year. This result, under such circumstances, must be highly gratifying to the managers of the institution, and it speaks well for the energy and efficiency of its staff. The report has been printed at the asylum press.

Annual Report of the Clonmel District Lunatic Asylum, for the year ending 31st March, 1857.

The resident physician, in a brief yet business-like address to the board of governors, directs

attention to the fact that during the past year the health of the inmates has been remarkably good; he points out, however, some grave defects in the present constitution of the establishment, owing principally to want of room. An abstract of the proceedings of the board during the year is appended.

A NEW BAROMETER.—Signor A. Secchi, of Rome, has invented a barometer, possessing several advantages, and remedying some of the imperfections which have heretofore interfered with the utility of the instrument. It has been for some months in use at the observatory at Rome, and is said to have yielded results exceeding the expectations of its inventor. The tube of the barometer, instead of being fixed, as usual, is left perfectly free, and is tied to the arm of a balance or lever, equilibrium being obtained by a weight at the other end of the balance. The variations of pressure are shown by the movements of an indicator, in the form of a long needle attached to the lever. In this mechanism the wider the tube the more sensible the weight, and by the use of sufficiently capacious tubes a considerable amount of motion can be obtained, sufficient to master friction, and to admit of the variations being registered on paper by a pencil attached to the indicator. The barometer is not so entirely new as Signor Secchi supposes. If we are not misinformed, there is one on the same principle in use at the Liverpool Observatory, under the care of Mr. Hartnup. The principle of self-registering has also been carried out by several inventors in this country.—*Literary Gazette*.

PUBLIC attention has recently been directed, through the medium of the *Times*, to the frequent and fatal occurrence of yellow fever on board the vessels of the Royal Mail Steam Company, in the West Indies. The case which has been most prominent is that of the *Orinoco*, which, in the voyage home, lost 28 men out of 75 attacked with fever—one man dying within a few hours sail of Southampton. Fortunately none of the passengers—168 in number—were attacked; but, separated from the sick, as many of them were, by a canvas screen only, their discomfort and apprehension must have been great and depressing. The focus of the disease appears to be the Danish Island of St. Thomas. In this island, on account of geographical convenience, the Royal Mail Company have established a coaling depot. On a wharf, formed of an old wreck, have been deposited several thousand tons of coal; the lower part of which "is undisturbed for years, and rests on a decaying foundation, with no breeze to carry off the miasma." Under these circumstances, it is not surprising that yellow fever should break out periodically at St. Thomas's, and that the epidemic should appear in every steamer which visits the wharf. The subject is one which calls for immediate attention; and it is to be hoped that the Directors of the Company will see the necessity of taking early and effectual measures to diminish or prevent the recurrence of such wholesale sacrifices. The correspondence to which we have referred is contained in the *Times* of July 18th and 20th; and in it we would specially direct attention to the letters of "A West Indian Traveller," and of the Rev. J. Radcliffe, Chaplain on board the *Orinoco*. Both these writers suggest means of improvement, which are worthy of attention.—*British Medical Journal*.

NEWSPAPERS FOR INDIA.—The post-office authorities have announced an important extension of the privileges of newspaper transmission to India—the payment of one penny franking a paper not exceeding four ounces in weight to any part of the Indian empire, *via* Southampton, and thence *via* Marseilles. These rates have hitherto only covered the transit to India, but they now include the subsequent carriage to the interior of the country.

QUEEN'S UNIVERSITY IN IRELAND.

At a meeting of the Senate of the Queen's University, held July 16th, 1857, the following gentlemen were elected examiners for the ensuing year:—Greek—Professor MacDouall, Q.C.B. Latin—Professor Lewis, Q.C.C. English Literature—Professor Craik, Q.C.B. Logic and Metaphysics—Professor Moffet, Q.C.G. Mathematics—Professor Boole, Q.C.C. Natural Philosophy—Professor Stevally, Q.C.B. Chemistry—Professor Rowney, Q.C.G. Anatomy and Physiology—Professor Harrison, T.C.D. Zoology and Botany—Professor Smith, Q.C.C. Modern Languages—Professor De Vericour, Q.C.C. Mineralogy, Geology, and Physical Geography—Professor William King, Q.C.G. Jurisprudence and Political Economy—Professor Heron, Q.C.G. Law—William B. Drury, Esq. Civil Engineering and Surveying—Professor Jack, Q.C.C. Agriculture—Professor Skilling, Q.C.G. Celtic Languages—Professor O'Donovan, Q.C.B. Medicine—Professor Ferguson, Q.C.B. Surgery—M. H. Collis, Esq., M.B. Materia Medica, Pharmacy, and Medical Jurisprudence—T. G. Geoghegan, Esq., M.D. Midwifery, and Diseases of Women and Children—Professor Harvey, Q.C.C.

APPOINTMENTS.

THE Lord Lieutenant has appointed Mr. James Stannus Hughes, M.D., Fellow of the Royal College of Surgeons in Ireland, to be Surgeon to his Excellency's household, in the room of Dr. Hatchell, promoted to the office of Inspector-General of Lunatic Asylums. Dr. Hughes already held the appointment of Surgeon in Ordinary to his Excellency.

THE NAVY.

ADMIRALTY, JULY 18.

Surgeon—J. F. Charlton to the *Tortoise*.

ADMIRALTY, JULY 20.

Surgeons—J. C. Sabben to the *Vulcan*; W. E. Hambly to the *Firefly*; A. Mitchell to the *Pylades*; P. Slevin to the *Pelorus*; J. F. Johnson to the *Mohawk*; D. J. Dingair to the *Assurance*; J. T. Cuddy to the *Roebuck*; F. T. Jones to the *Sparrowhawk*; W. Dickson to the *Chesapeake*.

Assistant Surgeons—W. T. Carr to the *Chesapeake*; W. Adam to the *Fisgard*; C. Morton to the *Victory*; J. Patterson to the *Pylades*; R. Edwardes to the *Pelorus*; G. R. Jenkins to the *Chesapeake*.

Acting Assistant Surgeon—M. Magill to the *Vulcan*. Surgeons—Henry Freeman to the *Calcutta*, for service with the 2nd Battalion of Marines for China; Henry H. Turnbull to the *Calcutta*.

Assistant Surgeon John Little, ditto.

Acting Assistant Surgeon—Astley Cooper, ditto.

Assistant Surgeons—William J. Baird and Doyle M'Shane, to the ditto, 1st Battalion; Thomas B. Warren, to the *Cambridge*; Craft G. Symons to the *Impregnable*; and James N. Dick to the *Wellesley*.

THE ARMY.

WAR OFFICE, Pall-mall, JULY 17.

4th Light Dragoons—Assistant-Surgeon W. Carte, from Staff, to be Assistant-Surgeon, vice Cullen, appointed to Rifle Brigade.

52nd Foot—Surgeon A. A. Stoney, from 94th Foot, to be Surgeon, vice Cowan, ex.

94th Foot—Surgeon T. Cowan, M.D., from 52nd Foot, to be Surgeon, vice Stoney, ex.

WAR OFFICE, JULY 24.

17th Light Dragoons—Assistant-Surgeon Yorke Hobart Johnson, from the Staff, to be Assistant Surgeon, vice Stanley, appointed to the 3rd Dragoon Guards.

20th Foot—Assistant-Surgeon Francis John Shortt, from the Staff, to be Assistant-Surgeon, vice Wright, appointed to the 38th Foot; Assistant-Surgeon John Munday, from the Staff, to be Assistant-Surgeon.

34th Foot—Assistant-Surgeon William Thomas Paliologus, from the Staff, to be Assistant-Surgeon.

42d Foot—Assistant-Surgeon Thomas Allen Thornhill, M.B., from the Staff, to be Assistant-Surgeon.

54th Foot—Assistant-Surgeon Daniel O'Donovan, M.D., from a Provisional Depot Battalion, to be Assistant Surgeon.

97th Foot—Assistant Surgeon William Dumbreck, from the Staff, to be Assistant Surgeon.

Rifle Brigade—Assistant Surgeon Alexander Frederick Bradshaw, from the Staff, to be Assistant Surgeon.

BREVET.

Deputy Inspector General of the Hospitals, Daniel Armstrong, on half-pay, to have the honorary rank of Inspector-General of Hospitals.

DEATHS.

On the 31st May, killed in action with the insurgent Sepoys near Delhi, in the 27th year of his age, STEWART MOORE, Esq., Assistant-Surgeon, 6th Dragoon Guards (Carabineers), youngest son of the late Hugh Moore, Esq., J.P., of Cottage Hill, in the county of Tyrone. Mr. Moore had served in the Crimea during the whole of the late war, and was present in the actions of the Alma, Balaklava, Tchernaya, and the siege of Sebastopol. He was killed by a grape shot, which fractured his skull, while attending the wounded in the above action.

DR. BADHAM, THE NATURALIST.—We regret to announce the death of a gentleman whose "ancient and modern fish tattle," and numerous papers on natural history in *Frazer's Magazine*, and other works, are well known—the Rev. C. D. BADHAM, M.D., who expired at East Berghott, Suffolk, on Tuesday, aged 51. Dr. Badham (who had practised as a physician, as his degree indicates), was latterly Rector of All Saints, Sudbury, Suffolk.

THE Danish papers announce the death at Copenhagen, on the 23rd of June, of CHRISTIAN MOLBECK, at the advanced age of seventy-four. He was professor of literature in the University of Copenhagen. Some idea of the extent of his writings may be formed from the fact that the mere enumeration of his published works occupies twelve closely printed pages of Ersler's Lexicon of Danish Authors.

On the 25th ult., MR. THOMAS BELLOT, F.R.C.S.E., Surgeon, Royal Navy, late of H.M.F.S. *Britannia*, Black Sea, and the Naval Hospital, Therapia, on the Bosphorus, having previously served in the East and West Indies, South Africa, China, and in command as Surgeon-Superintendent to Australia.

Dr. MAYER of Nuremberg, well known in literary circles as a translator of valuable works from the English and French languages, and editor of the *Mittelfrankish* newspaper, died at Nuremberg on the 30th of June.

On the 16th inst., on board the steamship *Colombo*, on his passage to Malta, JOSEPH HAMILTON DWYER, Esq., Surgeon of H.M.'s 14th Regiment.

On the 13th, at Madrid, Dr. JOHN ROBERTSON, Inspector-General of Hospitals.

TABLET IN MEMORY OF THE LATE SURGEON BRABAZON.—Surgeon Brabazon, in his capacity of Surgeon of the County Down Infirmary, was beloved for the kindness of his disposition, and his humane treatment of the patients; while a large circle mourned for him as an eminent practitioner called off in the flower of his life. He was a warm advocate of Masonry, and a willing supporter of the cause. He had attained the distinctive and eminent degree of Prince Mason, and was an office-bearer of the Provincial Grand Lodge of South Down. His brethren have erected, within the last few days, a beautiful, though neat and appropriate, tablet to his memory, in the wall to the right of the nave of Down Cathedral. The tablet is of monumental brass:—The following inscription is in church text, with red capitals and black small letters:—"In memory of Philip Emanuel Brabazon, P.G.R.C., who died August 26, 1856. Erected by several of his brethren of the County Down Masonic Lodge, No. 86." Underneath the inscription is his coat of arms, and the insignia of the order to which he belonged, and his crest surmounts it. The inscription is surrounded by finely executed engravings of masonic emblems.

PUBLICATIONS RECEIVED.

La Vaccine, ses consequences funestes. Par le Dr. G. C. Villette de Ferzé.

Quarterly Journal of Dental Science.

Midland Quarterly Journal of the Medical Sciences.

Annual Report of the Clonmel District Lunatic Asylum.

Annual Report of the Directors of Sir James Murray's Royal Asylum for Lunatics, near Perth.

Annual Report of the Royal Edinburgh Asylum for the Insane.

All our exchanges have been received, except the *Chemist* and the *Journal of Psychological Medicine*.

COMMUNICATIONS have been received from George Ross, Esq.; Dr. Abbott (Calcutta); Sir James Murray; Richard Lewis. E. S. will observe that his suggestion was anticipated.

ERRATA.

Page 213, line 4, 1st column, for "cervical," read "lateral."
Page 217, line 30, 2nd column, for "respiration," read "expiration."

TO ADVERTISERS.

ADVERTISEMENTS will be received for the DUBLIN HOSPITAL GAZETTE by BROWNE & NOLAN, to the 12th and 28th of each month. The following is the

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WHITWORTH AND HARDWICKE
HOSPITALS.

CLINICAL REPORTS OF MEDICAL CASES.

By DR. M'DOWEL,
Physician to the Hospitals.

CASE I.

Large Irreducible Femoral Hernia.—Doubtful symptoms of Strangulation.—Death from hæmorrhage into the Intestinal Canal.

(Reported by MR. M'FARLAND, Clinical Clerk.)

Mary Rush, aged 50, a servant, applied for admission into the Whitworth Hospital on Wednesday, July 9th, 1857, complaining of vomiting and of pain in the abdomen. She looked extremely ill, and was so weak that she had to be carried to bed. When visited a short time afterwards, she stated that she had a rupture, and on examination there appeared an irreducible femoral hernia on the left side, fully as large as the head of a child two years old; a small protrusion existed on the right side, which was quite reducible.

History.—The patient stated that the hernia had existed for 12 years; that she had always been able to reduce it without much difficulty, and that she had generally worn a truss; that she was in her usual health on that morning, and that whilst engaged in ironing some clothes, she suddenly felt as if something had given way, and thought that the hernia protruded more largely than usual; she had no truss on at the time; almost immediately she became weak and faintish, and vomited frequently. In less than three hours afterwards she was brought to the Hospital.

State of the patient on admission.—The patient complained a good deal of pain in the abdomen, which nevertheless was tolerant of pressure. She vomited frequently, and was restless. The pulse was weak and intermittent; the extremities were cold and the face was pale. Her aspect altogether was very like that of a person labouring under cholera.

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There was no diarrhœa however; on the contrary, the bowels had not acted since the day before. An immense hernia, as has been stated, occupied the left groin, it proved to be irreducible, but was neither painful nor very tense.

Nature of the case.—The great question to be determined was, did the symptoms depend upon strangulation of the contents of the hernia? I was soon convinced that the symptoms were not owing to this cause, and for the following reasons principally.

The great rapidity with which the symptoms had set in, was altogether unlike what usually is observed in cases of hernia. Had symptoms of strangulation existed for several days, the collapse and prostration would not have been difficult of explanation; but the symptoms had scarcely existed for more than three hours. No doubt the symptoms in strangulated hernia may set in with great rapidity, but this, as far as I know, has only been observed in small and recent herniæ; in voluminous protrusions of long standing, such as existed in the case under consideration, chronic strangulation is generally met with.

Lastly, although the hernia was irreducible, it was free from pain, and the attempts to reduce it caused no uneasiness. This was scarcely compatible with the existence of strangulation; some profound lesion, by which life was imperilled, had taken place, but I saw no reason to connect the hernia with it as its cause.

What was the lesion?

We thought of acute peritonitis; but the symptoms had been too rapid even for this. The same objection, but in a still higher degree, prevented us from regarding the case as one of gastritis merely. Cholera it could scarcely be, as there was no diarrhœa. Rupture of the stomach, or some portion of the intestinal canal, occurred to us as the lesion which would most satisfactorily account for the suddenness of the symptoms and the rapid super-vention of collapse.

Treatment.—A stimulant and purgative enema was directed; ether, with small doses of tincture of opium, was prescribed at short intervals; whiskey and wine were also freely given.

Progress of the case.—5 o'clock p.m. The patient had not rallied; she was perfectly conscious, but the pulse at the wrist could scarcely be felt.

Nine o'clock, p.m.—The surface was becoming cold, notwithstanding the free use of external warmth; the pulse could not be felt at the wrist; the voice was weak and indistinct, but the mind was unaffected, and the patient made no complaint of pain; vomiting had not ceased; the hernial tumor was in the same state.

The patient continued to sink, and died calmly about midnight.

Post-mortem examination, July 10.—No traces of peritonitis were found. The entire of the ilium and the greater part of the jejunum formed the contents of the large hernia. These intestines, as well as the remaining portion of the jejunum not included in the hernia, were filled with dark blood, partly fluid, partly coagulated. On a rough calculation there seemed to be about three quarts of blood thus effused. The intestines were perfectly healthy, though dark-coloured, as viewed with the blood as yet occupying their cavity. No ulcer or breach of surface could be detected. The stomach and liver presented no morbid appearance; no blood was found below the ileo-cæcal valve. The crural ring was of great size; the intestines which lay in the sac were in several places united by old white adhesions; and although the patient had stated that she could always reduce the hernia, the contents of the sac were so matted that we were forced to conclude that their complete reduction was almost impossible. They had, in fact, all the appearances of having long since "lost their right of domicile" in the cavity of the abdomen.

I believe that the cause of death in the case now detailed is one of extreme rarity. It would appear that the hernia was incarcerated, and thus such obstruction was caused to the venous circulation as to produce a general exhalation from the capillaries of the mucous membrane. The quantity of blood effused sufficiently accounted for the rapid occurrence of collapse.

Mr. Adams suggests that the sensation which the patient experienced of an additional quantity of intestine descending, may have been produced by the quick flow of blood into the coils of intestines contained in the hernia. Most likely this is the correct explanation; and it will be observed that in the history of the case, after this sensation was experienced, faintishness almost immediately supervened.

It would seem that the amount of obstruction which produced the hæmorrhage was also sufficient to prevent the blood from passing on into the large intestines; and hence, as no blood was passed from the bowels, the symptoms were insufficient to guide us in forming a strictly accurate diagnosis.

This case teaches us that strangulation of its contents is not the only risk attending a large

hernia, and illustrates how important it is that the subjects of hernia should always wear a well-adjusted truss.

CASE II.

Disease of the Aortic Valves.—Disappearance of the usual Physical Signs.

A man, twenty-eight years of age, extremely robust, but of intemperate habits, was admitted into the Whitworth Hospital, in October, 1856; he was labouring under anasarca, with great dyspnoea. All the signs of aortic patency existed, so much so that the case was often represented to the class as a perfect type of that disease. The heart was greatly enlarged; the pulse visible, full, and "collapsing." *Fremissement* was felt in all the large arterial trunks of the neck, whilst a rough double bruit existed in the sternal region, of which the bruit accompanying the diastole of the heart was the more intense. Bleeding was productive of great benefit, and by this, as also by the use of diuretics and diffusible stimulants, the dropsy was entirely removed, and the patient restored to a state of comparative health. From his history it appeared that the symptoms of cardiac disease had occurred rather suddenly, and that they had not existed for more than two months before his admission.

The patient was discharged on November 20. The advice which was given him to live temperately, and to abstain as much as possible from any unnecessary exertions, was wholly disregarded, and he was re-admitted on January 2, 1857, with all his former symptoms greatly aggravated. He was then unable to lie down, from the dread of being suffocated; the dyspnoea was most urgent. Hæmoptysis had occurred on several occasions, and he was again dropsical. On examining the heart, there was, as before, the same considerable amount of cardiac dullness; but we were greatly surprised to find that a bruit no longer existed. The most careful examination from day to day failed to discover any abnormal sound up to the time of his death, which did not occur for upwards of a month from this time. In fact, there were no longer the specific signs of aortic patency. There were the general signs of cardiac disease; but by an observer seeing him now for the first time, he would have been supposed to labour under mitral rather than under aortic valve disease; for the pulse had here become much weaker, and the œdema of the body obscured in a great degree the bounding appearance of the large arteries. For three days before his death the pulse ceased at the wrist, whilst the impulse of the heart was rather vigorous; from this circumstance the formation of coagula in the heart was suspected.

Post-mortem examination.—The heart was greatly enlarged, but especially the left ventricle, which measured six inches from base to apex. The enlargement of the organ was due to dilatation with

hypertrophy, the former preponderating. These changes occurred on both sides, but chiefly on the left. Four-fifths of the anterior aspect of the heart, as it lay *in situ*, was formed by the left ventricle.

The diseased condition of the aortic valves was obvious—one valve was healthy, but the septum connecting the other two having been destroyed by ulceration; those two flaps had become torn down, and capable of being removed by the rush of blood back into the ventricle; the coats of the aorta were healthy; white firm coagula existed in both the right and left cavities of the heart.

The absence of bruit during the last month of the patient's life was a very remarkable feature in the above case; in my opinion it was caused by the inability of the left ventricle to empty itself of its contents. The cavity of the ventricle had become so over-dilated that it probably was always more or less full of blood; the contraction of the walls of the ventricle was able to cause the column of blood to undulate, but was unable to expel it; and thus, as there was no space or cavity into which the blood of the aorta could fall, there was, therefore, an absence of the usual regurgitant murmur. Such at least seems to me to be the explanation of the absence of murmur in this instance.

DISSECTING ANEURISM OF THE AORTA.

CASE OF THE LATE DOCTOR BALL, LL.D.

(Communicated to the Dublin Pathological Society by
WM. STOKES, M.D., Regius Professor of Physic,
T.C.D.)

It is my painful duty to communicate to the Society the following particulars of the illness of the late Robert Ball, Esq., LL.D., who died March 30th after an illness of a few days' duration. Dr. Ball was a man of large stature, and robust looking, and at the period of his death *æt.* 54. In early life he was remarkable for his extreme bodily activity, and for the labour which he underwent in the pursuit of his favourite study, *viz.*, that of natural history. He was always remarkable for his temperate habits. Of the disease which terminated his useful career, there was no premonitory symptom for any length of time before his death. It was known to himself and to his friends that he had a very weak circulation; his pulse was remarkably small and occasionally intermitting. During the last year or two of his life, it was observed by some of his friends that in walking he moved slowly and apparently with caution, but it does not appear that he ever complained of any of those peculiar forms of dyspnoea, which are usually observed in cases of weak heart. About six weeks previous to his death he was attacked while walking in the street with a sense of faintness and vertigo, and was obliged to return home on a car; his senses, however, were unaffected, and

he recovered perfectly immediately after arriving at his house. On the day previous to the attack which terminated his existence, Dr. Ball was in the Museum of the Royal Irish Academy, showing to some strangers various specimens of Irish antiquities, and amongst them an ancient Celtic trumpet of great length, measuring when put together between six and seven feet; this instrument was not provided with a mouth-piece, so that to draw from it a musical note required a great muscular effort; few men in Dublin except Dr. Ball were able to accomplish it. On the day in question he blew this trumpet, and he subsequently expressed his opinion to Dr. Aquilla Smith (his usual medical attendant), that the efforts he made on that occasion in all probability produced the lesion which eventually proved the cause of his death. On the following morning, however, Dr. Ball arose to all appearance in perfect health, and said he had not felt himself so well for a long time.

On that very morning, however, during the act of shaving, he suddenly felt (to use his own words) "a smash within his chest." He at once lost all consciousness, and fell on the floor of his bedroom. The noise thus occasioned soon brought his family about him, who found him lying on the floor in a state of collapse. After a short time he recovered his senses; he referred the seat of his emotions to about the middle of the sternum, and remarked that he had received his death-blow. About an hour after this occurrence he was seen by Dr. Aquilla Smith, who found him in a state of collapse; the action of the heart was barely audible and his hands were cold and clammy; the stomach was distended with flatus, and he had vomited twice. Although the action of the heart was feeble it was perfectly regular; there was no murmur perceptible. He remained in that state until 4 o'clock that day. Upon the next morning (Friday, 27th) a consultation was proposed, but he requested that it might be postponed, saying that he felt himself getting better. He passed, however, a restless night, and on Saturday I saw him in consultation with Dr. Aquilla Smith; he remained all that day in what might be termed a semi-collapsed state, but his mind was perfectly clear. About midnight he fell into a state of collapse so complete that those around him feared he would not live many minutes longer; his intellect, however, remained perfectly unclouded; he took leave of all his family, and gave some directions about his affairs; he repeatedly observed that death seemed very slow in coming. The following day, Sunday, passed without any remarkable incident, he spoke of his case as of one in which some serious derangement had taken place in the vital functions, and gave directions that a *post-mortem* examination should be made, in order to ascertain what the nature of the lesion might be. During Sunday he took some chicken broth and some claret, and that night was singularly better and rather loquacious. On Monday I saw him again; he was

then, to all appearance, in perfect health; he had not the slightest symptoms of collapse, and had he been permitted would have got up and dressed himself; his pulse was full and perfectly regular, and a most careful stethoscopic examination of the region of the heart failed to detect the slightest departure from a state of health; there was no murmur, no unusual sound whatever. About 5 o'clock that evening he turned in his bed, and died shortly afterwards.

Upon the following day a careful *post-mortem* examination was made by Professor R. W. Smith, whose attention upon viewing the body was at once attracted by the appearance of the superficial veins, more especially those of the chest, shoulders, and arms; they were filled with a purplish coloured blood, and gave to the surface a mottled or marble appearance, frequently observed by Professor Smith in cases of fatty degeneration of the heart; throughout all the regions thus discoloured, a gentle pressure at once discovered the crackling of air in the subcutaneous cellular tissue. A layer of fat, fully three quarters of an inch in thickness, was cut through in the dissection necessary to remove the sternum. When this bone was removed the mediastinum was seen loaded with fat, in which the crepitation of air could be felt. The pericardium was greatly distended, and when punctured a large quantity of serum flowed out; when it was fully laid open a very large coagulum was seen completely concealing the heart from view. The heart was large, but not out of proportion to the size of the body; it was pale, soft, and flaccid; these alterations from its normal state were most evident in the right ventricle, through the walls of which the point of the finger could have been pushed with facility. The organ presented also a flattened and collapsed appearance, and when it was placed in water the surface of the fluid became covered with greasy and oily particles. The ascending portion of the arch of the aorta was considerably dilated, and the anterior surface, both of it and of the pulmonary artery, presented an ecchymosed appearance, from the presence of blood beneath their pericardial covering. When the aorta was slit up, a very extensive rupture was seen in its lining membrane and middle coat; its course was at a right angle with that of the vessel, three-fourths of the circumference of which were engaged in it; it was placed about one inch and a-half above the aortic valves.

The arterial tissues were separated from one another by the blood forcing its way between them both upwards and downwards, and in the latter direction this separation extended to the origin of the vessel. Immediately above the crossing of the pulmonary artery over the aorta, a small fissure, not more than one-eighth of an inch in length was seen in the serous covering of the latter vessel, and very near it there was a second aperture, not larger than the head of a small pin; through these the blood had oozed and accumulated in the peri-

cardium. The first and second portions of the arch of the aorta had undergone fatty degeneration, and masses of fat were deposited at the origins of the primary trunks and in the sinuses of Valsalva. The valves both of the aorta and of the pulmonary artery were cribriform and atrophied, and in many places as thin as it is possible to conceive, and perfectly transparent. The lungs were healthy. The abdomen was not examined.

DUBLIN PATHOLOGICAL SOCIETY.

The following interesting communications were made at a late meeting of the Pathological Society.

CANCER OF THE RECTUM AND LIVER.

By PROFESSOR BANKS.

Dr. Banks detailed the case of a woman aged about 40, but looking much older, who had been a patient in the Whitworth Hospital. She said that for some years she had been subject to constipation, as many as five or six days often passing over without any evacuation from the bowels. She had a pallid, sallow complexion. On examining her subsequently to her admission, the abdomen was found enormously distended and tympanitic; but there was no pain upon pressure. She stated that for seven days preceding her admission, nothing whatever had passed from the bowels, and that, three days before she came to the hospital, she was attacked for the first time with vomiting, which came on after every meal. These symptoms continued after she came into the hospital, without the slightest abatement. She was tried with numerous articles of food, but nothing remained upon her stomach; at length she was given iced brandy and water, which appeared to afford her relief, and was the only substance till then tried that was not rejected immediately; the vomiting, however, still continued; all means employed to relieve the constipation entirely failed. An œsophagus tube introduced into the rectum, after passing up the intestine for four inches, was suddenly stopped and turned upon itself. After some time the matter which she vomited assumed a dark brownish hue, and at length became almost black, with a strong fœcal odour. She died five days after her admission, there having been no motion from the bowels twelve days before her death.

On opening the abdomen after death, the large and small intestines were found greatly distended; the outer surface of the large intestine was of a dark greenish hue, there were some traces of peritonitis, the intestine being slightly adherent in some places. A mass of cartilaginous hardness was found constricting the rectum, about $4\frac{1}{2}$ inches from the orifice of the anus, to such a degree that nothing larger than a goose-quill could be passed through the strictured portion of the intestine. The stricture extended upwards for about one inch, and so

friable was the intestine just here, that it broke under the force used to take it from the body. On cutting into it at the seat of stricture, it was discovered that the hard substance which surrounded it was a mass of carcinomatous disease. The interior of the intestine and rectum, and indeed a great portion of the intestinal canal, presented very much the appearance which is observed in chronic dysentery. In some places the mucous membrane was extensively ulcerated. Numerous cancerous tubercles existed in the liver, but the stomach and the organs in the abdomen and pelvis were free from malignant disease.

LUXATION OF THE THUMB.

By PROFESSOR SMITH.

Professor R. W. Smith exhibited a cast of a dislocation of the first phalanx of the thumb on the front of the metacarpal bone, the reverse of Hey's luxation. The accident which caused the displacement had occurred many years since, in India. The man who was the subject of it was a farrier in a regiment, and while engaged in shoeing a horse, the animal plunged with great violence; but the patient could give no account (further than this) of the exact mode in which the thumb was injured. Repeated but useless efforts were made by the regimental surgeon to reduce the displacement. The cast showed very well the projection on the dorsal surfaces of the hand, caused by the end of the metacarpal bone; the extremity of the displaced phalanx could be distinctly felt in the ball of the thumb. Professor Smith alluded to a case of this injury recorded by Velpeau, in which neither the efforts of that surgeon nor those of M. Roux were successful in reducing the luxation. The result of these cases was quite opposed to the theory of Mr. Hey as to the cause of the extreme difficulty of reducing the ordinary luxation of the phalanx backwards.

CARIES FROM PLEGMONOID ERYSIPELAS.

By MR. GEORGE PORTER.

Mr. Geo. Porter exhibited an arm which he had recently amputated in the Meath Hospital. The patient, who was a woman aged 54, was, about nine weeks ago, attacked with plegmonoid erysipelas in the right forearm; she applied to a surgeon, who merely made a small puncture in the back of the hand with a lancet, which, of course, was of little or no service. She then applied for relief at the Richmond Hospital, where she was admitted under the care of Dr. Fleming, and where, after some time, amputation was proposed to her; but not having nerve sufficient to undergo the operation, she shortly afterwards left the hospital. Subsequently she went to the Meath Hospital, into which she was admitted under the care of Mr. G. Porter. She was then in a very exhausted state, owing to the profuse discharge of

purulent matter, which constantly issued from the openings which had been made; she was greatly emaciated, and over the sacrum there was a small bed sore. The patient recovered after amputation being performed. The preparation showed caries of the articulating portion of the ulna, and of its entire shaft; the lower carpal bones were also engaged; and beneath the palm of the hand there was a large abscess; the radius was not so much implicated as the ulna.

CIRRHOSIS OF THE KIDNEY.

By DR. LEES.

Dr. Lees presented a specimen of cirrhosis of the kidney, taken from the body of a man aged 52, who had been admitted into the Meath Hospital about a month before, labouring under chronic bronchitis and tuberculosis of the lung. He had been complaining of ill health for four years, his illness having commenced with an attack of bronchitis; he also suffered for a time from a severe pain in the head and loss of memory. After he had been a short time in the hospital, he drew Dr. Lees' attention to the very large quantity of urine he passed daily; it was very pale, nearly free from sediment, and of very low specific gravity. There was no appearance of any dropsical effusion. Dr. Lees was of opinion that the patient laboured under one of those forms of Bright's disease in which the kidney is contracted in size. The only cerebral symptom present was severe pain in the head, accompanied by vertigo. He lingered for a few weeks, and died in a state of syncope. Upon examination after death, the kidneys were found to be the seat of granular degeneration; they were small and contracted, and the capsule was very adherent to each. Dr. Lees alluded to the opinion of Dr. Corrigan, that there were two forms of Bright's disease: in one of these, which he terms cirrhosis, the kidney is contracted, and he considers it to be a distinct affection from that in which the organ is enlarged; in the latter dropsy is generally present, while in the former it is often absent. In the present case the peculiar degeneration in question had implicated both the cortical and medullary structures of the organ. It is worthy of notice there were no convulsions in this case, nor was there the slightest appearance of dropsy at any period of the case.

MORBUS COXÆ.

By MR. HAMILTON.

Mr. Hamilton exhibited a specimen of very aggravated disease of the hip-joint. A young man twenty-two years of age, was admitted labouring under the symptoms of ulceration of the cartilages of the hip-joint, accompanied by severe irritative fever. After a short time a large abscess formed beneath the glutæi muscles and was opened. Another formed under the tensor vaginæ

femoris, which also was opened. Other abscesses then continued to form rapidly, and burst in different parts around the joint. Suddenly he became much worse; the symptomatic fever increased, and he began to have more frequent and severe startings of the limbs; the position of the thigh also became altered, and it assumed all the characters of dislocation upon the dorsum of the ilium. This form of dislocation, as is well known, resulting from hip-joint disease, is by no means uncommon; indeed, it might be termed one of its most frequent results. Occasionally we meet with rarer forms of dislocation in this joint attributable to morbus coxæ.

The patient died of hectic fever soon after his admission into the hospital. Examination of the joint showed a good example of that disease of the hip in which the acetabulum becomes stripped of its cartilage, its brim absorbed, and its surface carious; the bone is often seen split into its original three pieces. Although the cavity of the acetabulum was in reality deepened, it appeared to be shallow from the destruction of the brim. The bottom of the acetabulum was not perforated, as we find it to be in some cases, although a provision had been begun by nature to supply the possible destruction of the bone by an ossific deposit on the internal surface of the pelvis, corresponding to the fundus of the acetabulum. Nearly half of the head of the femur was destroyed, and on its surface there were eminences corresponding to the irregularities of the acetabulum. We generally find in cases of this nature that the head of the bone is drawn to the upper and back part of the acetabulum, and retained in that situation by the action of the muscles. This preparation, then, presented a very good example of that form of disease of the hip-joint which so nearly simulates dislocation upon the dorsum ilii, although in reality none existed.

Dr. Hamilton then exhibited a drawing which illustrated a luxation of the head of the femur into the foramen ovale, resulting from morbus coxæ, and in which the symptoms were similar to those observed in cases where it is the direct consequence of violence; and another showing the appearances presented in the more common form of dislocation resulting from hip-joint disease, that is to say, dislocation upon the dorsum of the ilium.

APOPLEXY.

By Dr. Banks.

Dr. Banks exhibited a specimen of apoplexy, taken from the body of a woman aged 48, who was admitted into the Whitworth Hospital on the 23rd of April last. It was stated by her friends that on the preceding day she had been found lying on the kitchen floor in a state of insensibility, from which it was impossible to rouse her. When admitted into hospital she was completely comatose, and the entire of the right side was paralyzed; the fingers were flexed, and the fore-arm was also rigidly flexed upon the arm; her

breathing was stertorous and laboured; deglutition was impossible, and the evacuations passed away involuntarily. She died on the night of the 24th, the day after her admission, and two days and a half from the date of the seizure. Upon opening the cranium, a considerable effusion of blood was found to have taken place beneath the arachnoid membrane, in both hemispheres of the brain. The left hemisphere felt like a bag of fluid, and when cut into, this was found to contain about four ounces of blood, by the extravasation of which its substance was extensively lacerated. There is one circumstance connected with this case worthy of notice, and that is, the state of rigidity of the flexor muscles on the right side. It sometimes happens that when a clot of blood exists in the brain, the muscles are in a state of complete relaxation, whilst in other cases, under apparently similar circumstances, they are, on the contrary, rigidly contracted. This apparent contradiction has been explained by Dr. Todd in his Clinical Lectures: he says that in the former case, where the muscles are relaxed, the clot does not extend beyond the diseased portion of the brain; but in the latter, the clot ruptures the substance of the brain, and presses upon the origins of those nerves which go to supply the affected muscles, thus producing irritation.

ON THE PRESENCE OF ELASTIC PULMONARY FIBRES IN THE SPUTA OF PHTHISICAL PATIENTS,

AS A CERTAIN SIGN OF THE EXISTENCE OF A VOMICA.

By J. L. C. SCHROEDER VAN DER KOLK,

Professor in the University of Utrecht.

Translated from the Dutch by

WILLIAM D. MOORE, A.B., M.B., T.C.D.,

Honorary Member of the Swedish Society of Physicians.*

Physicians have long felt the importance of discovering a certain sign by which the sputa of a phthisical patient might be distinguished from those coughed up in a chronic catarrhal inflammation of the lungs; and, as a copious formation of pus occurs in the former, the attention of observers has been chiefly directed to the acquirement of an

* Several years have elapsed since I first became acquainted, through the medium of Herre Ekströmer's Swedish translation, published in the *Hygiea* for January, 1850, with the valuable observations of Professor Schroeder van der Kolk upon the above important subject. These observations have been briefly alluded to in the 22nd volume of the *Dublin Quarterly Journal of Medical Science*, and very fully in the second volume of the present series of this Journal, in a review, by Dr. Banks, of Dr. Biermer's work, "Die Lehre vom Auswurf;" but considering it desirable that we should possess a translation in *extenso* of the memoir in question, in the absence of any information as to where the original was to be found, I applied to the distinguished author

adequate distinguishing mark between purulent sputa, and those containing only thickened mucus: It is well known that even Hippocrates* has stated that pus, when burned, emits a foetid odour, and that it sinks in sea-water, while mucus does not.

This inquiry, not only as to whether it may be possible, in reference to sputa, to ascertain whether they consist solely of condensed mucus, or contain pus, but also whether we might be able in them to distinguish the matter of pulmonary tubercle, and so be in a position to decide on the existence of a vomica, and to recognise phthisis pulmonalis in its commencement, has given rise to very many different experiments and propositions, of which, unfortunately, not one has, as yet, led to any certain result.

Formerly it was attempted to discover the difference chiefly by chemical means; and it is well known that our Brugnans thought he had attained this object, inasmuch as he believed that pus was capable of undergoing acid fermentation, while mucus was not.† But the mistake was here committed of seeking a distinguishing mark between pure pus and pure mucus, and endeavouring to make this applicable to purulent mucus. Pure pus is, however, so easily discriminated from pure mucus by the eye alone, that in ordinary practice we need no chemical aid for this purpose; while, on the contrary, experience shows, that the several means of distinction are wholly useless, when applied for the purpose of diagnosing with certainty pure thickened mucus from mucus in which pus is at the same time present, since, in the several degrees of admixture, the tests are not sufficiently accurate. I shall here mention only Grasmeyer's test,‡ which longest maintained its ground, namely—mixing pus with a solution of carbonate of potash, whereby it is converted into a gelatinous mass, while no such change is produced with mucus. Or Huenefeld's§ proposal, to boil the sputa with sal ammoniac, by which they were said to be coagulated, if pus were present. Neither of these methods, however, affords a certain test. Equally little reliance can be placed on the fact advanced as a test by Gueterbock|| that pus, in virtue of its fatty contents, burns with a flame, whereby, he says, we may distinguish purulent sputa from any others; for this character is by no means sufficiently well marked, and fat is also met with in thick bronchitic sputa. I have

himself, and I am glad to avail myself of this opportunity of expressing my thanks to him for the kindness and readiness with which he at once sent me the last remaining copy of his essay, which, it appears, was originally published in the *Nederlandsch Lancet*, second series, first year, seventh part.—TRANSLATOR.

* *Coacc prænol*. Ed. Linden, T. 1, p. 255.

† Brugnans, *Dissert. de Puogenia*, p. 215. Gron. 1785.

‡ *Abhandl. v. Eiter*, etc. Gött. 1798, p. 59.

§ See Berzelius, *Thierchemie*, p. 599.

|| Gueterbock, *De pure et granulatione*. Berol., 1837, p. 25.

myself found the mucus on the inner surface of the finest ramifications of the bronchi, in an otherwise perfectly normal lung of an elderly woman who had died of hydrothorax, tolerably largely mixed with fat, although no trace of inflammation was perceptible in this case. Brett states that he has found acetic acid to be capable of coagulating mucus, but not pus. However, as mucus is always present in purulent sputa, this agent will not enable us to distinguish the latter. The subject will be found more fully treated of in the works of J. Vogel,* Gueterbock† and others.

Subsequently another method has been proposed, and it has been thought that the improvement of the microscope should furnish a means of distinguishing, with greater certainty, pus from mucus. This inquiry has given rise to a great number of essays on the form in which pus exhibits itself under the microscope, and on the difference between pus and mucus. Thus, after the discovery in pus of peculiar, more or less granular corpuscles, it was thought that through these the presence of pus could be accurately determined; and Vogel asserts, in his above-mentioned work, that we can, with the aid of the microscope, even in a mixture of pus and mucus, decide, of each smallest particle, though invisible to the naked eye, whether it is pus or mucus.‡ This writer, however, seems not to have observed that the same corpuscles occur also in inspissated mucus, and are not wholly absent even in healthy mucus from the mouth. Thus I have always found them, though in small quantity, in the saliva. They agree so closely with the corpuscles present in pus, that they cannot, indeed, be distinguished from the latter; though they may be somewhat more transparent—yet are they so like in form and size, that when mixed with pus corpuscles, it is impossible to distinguish them, and both, therefore, appear to belong to the same kind of formation. Simon§ gives a tolerably good representation of them, taken from nasal mucus and thin bronchial mucus. Gluge|| says that mucus-globules are always one-fourth larger than pus globules, and that they never exhibit any points (granulations?) I have often met them of the same size as pus corpuscles, and always found them granular. Henle¶ makes the same figure represent both pus and mucus corpuscles,** so that it does not in fact appear whence they are taken.

Buhlmann†† also acknowledges that these mucus corpuscles render the idea of pus globules uncer-

* J. Vogel, *Ueber Eiter, Eiterung*, etc. Erlangen, 1838, pp. 96 et seq.

† Loc. cit., p. 3 et seq.

‡ Loc. cit. p. 108.

§ *Med. Chem.*, 1842. T. 2, st. 2, fig. 15 and 16, p. 310.

|| *Anat. micr. Unters.* H. 1. Mind. 1838, p. 26.

¶ *Ally. Anat.* p. 155, &c., tab. v. fig. 22.

** *Ally. Anat.*, p. 939, and explanation of the figures, p. 1025.

†† *Beiträge zum Kenntniss der kranken Schleimhaut der Respirationsorgane*, Bern. 1843, p. 30.

tain and doubtful. He considers them, however, to be exudation globules, arrested at a certain stage of their formation, and says that they occur not only in nasal and in bronchial catarrh, but also very plentifully in incipient tubercle.* These inflammatory globules are, however, usually larger, and exhibit a more granular appearance. Vogel gives a very good representation of them,† and found them also in tuberculous matter taken from the lungs.‡ In inflammation I have often met them; they can very easily be distinguished from pus and mucus globules.

If we now put together the different modes in which pus globules have been described and delineated by different writers—of which Buhlmann§ gives a good review in his above-mentioned work—that they occur also in a slight catarrh, and that even in chronic catarrh, the purest pus may be secreted, entirely agreeing with phthisical sputa,|| we shall be convinced that they cannot be with any certainty employed as a distinctive mark of suppuration, or of an incipient vomica; so that in my opinion they incorrectly bear the name of pus globules.

Other writers have, however, thought that in the sputa of phthisical patients, tubercular matter can be recognized under the microscope, and that thus a decision can be arrived at as to the existence of tubercular suppuration in the lungs, and the formation of an incipient vomica.

Vogel has represented as such, a granular mass which often occurs in the sputa of phthisical patients, and which he considers to be the product of tuberculous matter. This is found also in tubercles in dead bodies; and on this Vogel¶ grounds his supposition. Buhlmann,** however, correctly observes, that this granular mass occurs also in chronic catarrh, and is therefore far from characteristic. It consists, according to him, of coagulated albumen globules, which have united into groups. Gluge†† also describes the same, and says he has constantly met this granular mass, with compound inflammatory globules and pus corpuscles, in tubercular pus. In the same manner Vogel,‡‡ in his late work, gives a representation of tubercular matter, taken from a tubercle. This consists, according to him, of smaller cells, larger inflammatory globules, and a granular mass.

As, however, these forms seem to occur as products of inflammation in sputa, where only chronic catarrh is present, they can be of no use in lead-

ing us to a conclusion as to the existence of tubercular matter.

Gruby* appears to have fallen into a much more serious error; thus, he describes as characteristic of tubercular matter, globules said to occur in the sputa, with concentric spiral rings (sphæra lenticulares), which are nothing else than badly-drawn starch granules from food which has remained between the teeth, or in the throat. Of the same nature are the expectorated pulmonary cells represented by him, which have nothing in common with the form of pulmonary cells, and by their regular rhomboidal shape at once betray themselves as vegetable cells: so that I am very much surprised that Buhlmann† has not recognised them as such, and that he has drawn them again. He says he has seen something of this kind; but that they must have been very much altered by the suppurative process; wherefore he expresses some doubt as to Gruby's beautiful figures. Gruby's sphæra lenticulares he could not find; and he states that he is quite uncertain as to what Gruby has seen,‡ although Simon§ a year before discovered that they were nothing but starch granules, which he said immediately turned blue by the addition of iodine. Dr. Gobée has, however, lately described them again at considerable length, and has given various drawings of them.|| He says he once saw them in the sputa of a peripneumonic patient, but took them for something accidental. In actual tuberculosis, he had never seen them. We may safely look upon them as starch granules, having nothing in common with the sputa of tubercle.

Gerber describes many kinds of tuberculous matter, as albuminous or unorganized, fibrous and hyaline tubercle, cellular tubercle, fibrocellular tubercle, and, finally, melanotic and organised tubercle. Buhlmann¶ observes on this point, that in numerous examinations of tubercle, he found no other constant product than albuminous globules, or granules. The various kinds described by Gerber he could not find; neither have they occurred to me. Dr. Gobée says he has observed such organised tubercular matter in the sputa of a patient; and he represents oblong cells, which he thinks are elementary cells, in their transition to form fibres,** and actual fibres, having most conformity to recently developed connective fibres.†† If we examine an air tube and its bronchial ramifications in a healthy lung, we shall soon find that the oblong, boat-shaped, bottle, and thorn-shaped

* Loc. cit. p. 43.

† J. Vogel, *Icones histologiæ patholog.* Lips. 1843, tab. iii., fig. 13 and 14, B.

‡ Loc. cit. tab. xv., fig. 3, c.

§ Loc. cit. p. 19 et seq., tab. i. fig. 14, 18—20, Tab. ii., fig. 1—11, 20, 21. Tab. iii., fig. 1—8.

|| Buhlmann, loc. cit. p. 39.

¶ Vogel, *über Eiter*, &c., p. 112, fig. 10.

** Loc. cit. p. 59.

†† *Anat. Microscop. Unters.* Heft 1. Minden, 1838, p. 21, tab. xi., fig. 5. Heft 2, p. 181.

‡‡ *Icones Histolog. path.*, tab. xv., fig. 111.

* Gruby, *Observ. Microscop.* Minden, 1840. See also Buhlmann, loc. cit., tab. i., fig. 10, 12, 15, 16.

† Buhlmann, l. c., p. 65, tab. i., fig. 17.

‡ Buhlmann, p. 59, et seq.

§ Simon, *Med. Chemie.* Berlin, 1842. Bd. ii. Heft. 2, p. 316, note 2.

|| Dr. C. Gobée, *Tijdschrift voor wetenschappelijke Geneeskunde*, D. ii., et. ii., pp. 108, &c.

¶ Loc. cit. p. 60.

** Gobée, loc. cit. p. 113, fig. D.

†† Loc. cit. p. 114, fig. E.

cells of Dr. Gobée are nothing else than more or less destroyed portions of the ciliated epithelium with which the air passages are lined even to their finer ramifications. Of the same nature appear to be his recently-formed fibres, differing completely from the fibres of which I shall hereafter speak. Dr. Gobée, however, thinks that out of the albuminous and fibrinous matter exuded in the lungs his oblong cells are formed as elementary cells, which pass into actual connective tissue, whereby an obstruction, and through the new formation of connective tissue, an actual enlargement of the pulmonary vesicles must take place, giving rise to asthmatic phenomena.* We can, however, in the present state of our knowledge of the development of connective fibres, scarcely admit their new formation in the sputa.

I am also greatly surprised to see that Dr. Gobée states, as a peculiarity, the formation, after the addition of acetic acid, of a great quantity of long thick threads, which so increased on further addition of the same re-agent, that the entire presented the appearance of a membrane composed of connective tissue. It is, however, a well-known fact, that mucus solidifies on the addition of acetic acid, and thus assumes under the microscope the form of thick transparent threads, and even membranes, which I have often also observed in nasal mucus, which have no reference to the formation of tubercle, and possess no peculiarity, except that they may easily mislead an incautious observer.

Lebert† gives, as a peculiar characteristic of tubercular matter, the presence of irregular oblong corpuscles of 0·05 millimetre, possessing no nuclei, as is shown by adding acetic acid, and which, together with many molecular granules, are agglutinated by a clearer matter. In order to see these well, the tubercular corpuscles should be thinned with a little water, as otherwise they are too compact. They are said to afford the most certain distinctive make of tubercular matter, as pus-corpuscles possess nuclei, and measure, on an average,‡ 0·01 of a millimetre in diameter. When these tubercles soften, the tolerably solid matter which held the corpuscles agglutinated in the tubercles, begins to grow fluid; the tubercular bodies become free, enlarge, and assume a more spherical shape.§ If pus globules intervene, these come, according to him, not from the tubercular mass, but from the surrounding parts. The tubercular globules, however, rapidly dissolve, especially if they are mixed with pus;|| and this is, according to Lebert, the reason why they are scarcely ever met with in the sputa, in which, he confesses, he has never, with certainty, observed them.¶ Hence,

it follows, as a matter of course, that these corpuscles, at first described by Lebert as so characteristic, have no diagnostic value; and he himself also acknowledges that the microscopic examination of the products of expectoration in phthisis can contribute nothing to clear up the diagnosis, especially when the disease is still in the incipient stage.

From all this we see that neither chemical re-agents, nor the microscope, have furnished us with the means of distinguishing pus from mucus in sputa, of recognising the presence of pus in mucus, or of demonstrating that of tubercular matter.

Having been, however, for some time engaged in the examination of the sputa of phthisical patients, I discovered therein peculiar fibres, which, by their special course and characteristic form, I recognised as elastic fibres surrounding the air cells, and therefore appearing to me calculated, in the absence of any other distinguishing mark in the sputa, to afford a very characteristic sign of the existence of a vomica. Having thus had my attention directed to the point, I found them in all the sputa of phthisical patients which subsequently came under my observation, and, indeed, in the most opposite stages of the disease.

(To be continued).

CASE OF TRAUMATIC ANEURISM OF THE COMMON CAROTID ARTERY.

By JAMES SYME, Esq.,

Professor of Clinical Surgery in the University of
Edinburgh.

In the early part of last month I received the following letter from Mr. Haldan, of Ayr:—

Ayr, 10th June, 1857.

MY DEAR SIR—I saw a man named David Craig, living in the neighbourhood of Dailly, yesterday. He has an aneurism, of considerable size, on the left common carotid, low in the neck. I advised him to lose no time in putting himself under your care, if you will have the kindness to admit him into your wards. The history is as follows:—Seven weeks ago, in a brawl, he was stabbed in the neck, on the left side; the wound was about an inch in extent superficially, and situated immediately over the track of the great vessels, an inch and a-half above the sterno-clavicular articulation. The wound was received in a rather dark room, about two o'clock in the morning, and he was discovered almost immediately after lying in a great quantity of blood. I believe the hæmorrhage had by that time stopped. About four o'clock in the afternoon, while answering some questions that were being put to him by a police-constable, violent hæmorrhage again occurred, and in five minutes he was all but dead. The hæmorrhage is described as not having occurred per saltum, but the blood as being of a rather red colour. I saw him, as a medico-legal case, twenty-five hours after the injury. He was then very pale and weak. The wound had been brought together by three sutures after the second bleeding. There was a small flat tumor, as of a clot, lying over the vessels, and to which a pretty firm impulse was communicated. The pulsation of the right

* Gobée, l. c., p. 114, et seq.

† Lebert, *Physiologie pathologique*. Paris, 1845. T. 1, p. 352, pl. viii., fig. 1, 2.

‡ Lebert, loc. cit., p. 356, 358.

§ Lebert, loc. cit. pl. viii., fig. 4 and 5.

|| Lebert, l. c. p. 366. ¶ Ibid. p. 413.

carotid was very feeble. The opinion I formed and gave was, that the hæmorrhage came from the internal jugular vein, and that it was possible that the carotid had also been injured, though not laid completely open, through all its coats. I did not see the case again till yesterday, when I was informed that the small tumor observed after the injury slowly decreased in size, and about eight days ago, the present tumor was observed, and that since that time it has been rapidly increasing. —I am, my dear Sir, yours very faithfully,

JOHN C. HALDAN.

The man was to go into Edinburgh to-day.

The patient, a young man, æt. 20, was admitted into the hospital on the 10th of June. The aneurism, which was about the size of an orange, extended in a transverse direction from the trachea to the outer edge of the sterno-mastoid, and downwards close to, or rather under, the clavicle, throbbing throughout with great force. Nearly at the centre there was a cicatrix, showing where the wound had been. In the course of a few days, notwithstanding confinement to the horizontal posture, and low diet, there was a distinct enlargement of the tumor, so that it seemed necessary to decide without delay upon the course to be pursued.

The case was obviously one of great responsibility, involving as it did, not only the patient's life, but also that of his assailant. There could be no doubt that if the aneurism were allowed to proceed, it would, before long, prove fatal by interfering with respiration, or opening inwardly, if it did not do so upon the external surface. On the other hand, it was evidently impossible to tie the artery below the tumor, while an aperture could not be made into it without subjecting the patient to urgent and extreme hazard. The wound of the artery might be opposite the cicatrix, but it might also be situated at a lower point, if the knife, as was not improbable, had a downward direction, in which case it would hardly be possible to apply a ligature; and, wherever situated, it could afford little assistance in discovering the vessel, since the pressure which had been in operation for nearly two months must have so consolidated the textures as to render their recognition and separation equally difficult. There thus seemed to be not only a great risk of the hæmorrhage proving uncontrollable, but a hardly less formidable danger of injuring the internal jugular vein. Having carefully balanced these different considerations, I arrived at the conclusion that it was my duty to give the patient his only chance of escape; and, encouraged by the concurrence of my colleagues, proceeded to perform the operation on the 17th of June.

Chloroform having been fully administered, and the patient being placed upon his back, with his shoulders slightly elevated, I pushed a knife through the cicatrix, and followed the blade with the forefinger of my left hand so closely as to prevent any effusion of blood. I then searched through the clots and fluid contents of the sac for the wound

of the artery, and found that pressure at one point made the pulsation cease. Keeping my finger steadily applied to this point, I laid the cavity freely open both upwards and downwards, turned out the clots, and spunged away the fluid blood so as to get a view of the bottom, which presented the smooth shining aspect of a serous membrane without the slightest indication of either the artery or vein that could be seen or felt. In order to make the requisite dissection, I next attempted to close the orifice by means of forceps, but found that it had the form of a slit which could not be thus commanded. It was also so near the clavicle, that pressure could not be employed below it, and, to my still greater concern, lay on the inner or tracheal side of the vessel, so that the compression required for its closure, instead of being backwards upon the vertebrae, was outwards upon the vein. In these circumstances, it seemed proper, so far as possible, to lessen the opposing difficulties; and I therefore ran a bistoury through the skin and the sternal portion of the sterno-mastoid, so as to divide this part of the muscle, together with the superjacent integument. I then seized the edge of the slit in the artery as it lay under my finger with catch forceps, and desired them to be held, as to draw the vessel towards the trachea; then carefully scratched with the point of a knife and the arterial coat was brought into view, at its external edge, a little above the aperture, where a ligature was passed by the needle and tied. I repeated the same procedure below the wound, and when it was completed, had the satisfaction of finding that my finger could be withdrawn without the slightest appearance of bleeding, instead of the tremendous gush which had previously attended its slightest displacement. The ligatures separated on the tenth day, and the patient, who had suffered no inconvenience since the operation, was dismissed on the 17th of July.

I have thus particularly related the steps of the operation, because it was by far the most arduous that has ever occurred in the course of my surgical experience. When venesection was more in fashion than it is at present, I had nine times occasion to operate for traumatic aneurism at the bend of the arm; and therefore was, in some measure, prepared for the difficulties to be encountered, which nevertheless proved nearly insurmountable. Indeed, even now, I cannot without a shudder reflect on my position, when the movement of one hand must have instantaneously caused a fatal hæmorrhage from the carotid artery, and a slight deviation of the other would have given issue to an irrepressible stream from the jugular vein.—*Edinburgh Medical Journal.*

EXCISION OF THE ENTIRE SCAPULA has been performed lately with success by Dr. Crawford of Ayr. Very little blood was lost. The patient was under the influence of chloroform for fifty-five minutes.

A CASE OF ACUTE POISONING BY PHOSPHORUS.

By Dr. TH. NITSCHÉ.

A soldier, æt. 21, previously healthy, was received into hospital on the 21st of May. On closely interrogating the patient he admitted that on the 19th he had attempted self-destruction: that he had first swallowed all the mercury in a barometer, but that this passing away by his bowels, he determined on resorting to phosphorus. On the evening of the 20th, he took the ends of six ordinary packets of phosphorus matches and in three hours afterwards was seized with vomiting, which occurred frequently; and during his passage to the hospital, a large quantity of the matches were expelled from the stomach. On being received into the military hospital, his pulse was frequent, and tongue loaded; his head was hot, and he complained chiefly of headache. Auscultation and percussion revealed only a somewhat increased area of hepatic dulness. With the view of removing from the stomach the phosphorated ends of the matches which remained, an emetic of ipecacuanha and tartarised antimony was given; cold applications were directed to the head, and subsequently magnesia milk in considerable quantity was administered. After the emetic, the stomach ejected a greenish fluid which contained portions of undigested food, mucus, and some ends of the phosphorus matches. The fluid did not emit any odour of phosphorus. On the following morning (22nd) the symptoms were little changed. The headache was less severe; pulse 92, face red, the region of the stomach slightly sensible to pressure, and the patient complained of commencing pains in each hypochondrium. The magnesia was continued. In the afternoon the turgescence of the face had increased, as had also the hypochondriac pains, and there was burning thirst, with dryness of the mouth. The head-ache had completely disappeared. The urine was high coloured and frothy, its specific gravity increased, and it was found to contain albumen and exudation cells; the colouring matter was augmented as were also the sulphates and phosphates, but the chlorides were diminished in amount. This state of the urine continued during the whole course of the disease. The estimate as to the quantitative analysis of the urine was only taken by the eye, so that it is not of much value. On the 23rd, three days after the poison had been taken, the thirst and dryness of the mouth, with the hypochondriac pains, had increased and there were, moreover, darting pains in the chest. The turgor of the face was heightened; the sensibility of the epigastric region more marked, and the tympanic percussion sound of the stomach audible over a greater extent. Giving credence to the general impression that phosphorus induces inflammation of the stomach, leeches were applied to the epigastrium, and iced applications employed.

Ice was also given with the view of assuaging the intense thirst. The magnesia was continued. Up to the afternoon the symptoms had undergone no alteration, except that the face had assumed a remarkable blueish-red colour, from which, however, the middle of the face was perfectly free; a colourless band of about an inch in breadth, extended from the highest point of the forehead to the chin, and was sharply defined, giving to the face a most peculiar appearance.

The bowels not having acted since the poison was taken, an enema was administered, which produced an evacuation of a yellowish hue, but not possessing any odour resembling that of phosphorus. Owing to the carelessness of the attendants, the opportunity of chemical examination was lost. On the 24th (the fourth day) the pains in the hypochondrium had to some extent abated, but those of the breast had become intolerable, notwithstanding which, a physical examination of the chest did not show any remarkable change in the respiratory organs. The blueish-red colour of the face had changed into a perfectly cyanotic hue, the median line continuing free from all colour. The epigastric pain ceased; the patient sweated profusely, and the vapour arising from the body gave out an intensely phosphoric odour, particularly perceptible on raising the bed-clothes. The breath was perfectly odourless.

A peculiar symptom now shewed itself, viz.: the deprivation of sight. The patient, who retained perfect consciousness, stated that in the horizontal posture he could perceive a feeble ray of light, but that when he sat up he could not see at all. The pupils were so dilated that only a narrow ring of the iris was visible, and they were uninfluenced by light. He now complained of darting pains in the eyeballs; the pulse was 100, but moderately full and strong. In the afternoon, the pulse rose to 140, and was small and weak; the sense of hearing was lost; the sweat was profuse, and the odour of phosphorus was stronger than in the morning; the extremities were cool, and the second sound of the heart and great vessels were no longer audible. The patient, who still retained perfect consciousness complained of severe pains in the chest. At seven o'clock in the evening, the case terminated in death, which was perfectly tranquil. On the morning of the 26th an examination of the body was made.—The brain was pale, bloodless, and softer than natural; the ventricles contained a minimum quantity of serum; the sinuses were distended with dark fluid blood. The lungs were of a dark red colour; in the right were many patches of blood-extravasation; the sub-pleural cellular tissue had numerous ecchymoses, and the cellular tissue of mediastinum presented the same appearances. In the pleuræ there was much bloody serum. The pericardium contained a little reddish serum; the heart was soft, the left ventricle empty, the right ventricle and the great veins contained much blood, partly in a state of loose coagulation, and partly

fluid. The liver was to some extent enlarged, fatty and perfectly bloodless. In the stomach there was some greenish fluid, with white flakes; and to the surface of the lining membrane much thick mucus adhered. With the exception of the fundus of the stomach, which was somewhat hyperæmic, the interior of this viscus did not exhibit any abnormal appearance. The mucous membrane of the œsophagus and pharynx was normal; that of the duodenum resembled the stomach. Along the course of the intestines, in many situations, the sub-peritoneal cellular tissue presented patches of ecchymosis. The small and large intestines did not contain anything unusual; in both there was a moderate quantity of yellow fæces. The spleen was bloodless; the cortical substance of the kidneys was granular. The malpighian corpuscles presented a beautiful appearance, and resembled red points. On a microscopic examination the remarkable malpighianum was found injected, and the uriniferous tubuli blocked up with exudation matter. The mucous membrane of the pelvis of the kidney presented some spots of ecchymosis. In the urinary bladder, which was contracted, a little cloudy urine was found. The stomach and a portion of intestines, with their contents, were conveyed to the laboratory of the "Josephs-Academie," where a chemical examination was instituted, but without succeeding in discovering the presence of phosphorus. There was no smell of phosphorus from the body, and it may be observed that neither on the body during life, nor after death, was there any appearance of phosphorescence.

The narrator of this most important case of poisoning by phosphorus, regrets that owing to the pressure of business, in a great hospital, it was found impossible to carry out as minute an examination as might have been desirable, particularly in a chemical point of view; but he deems the publication of the case valuable, as giving an accurate detail of the symptoms observed during life, and also of the *post-mortem* appearances, as such erroneous views prevail as to the effects of phosphorus on the system.

The most important results of the examination were, on the positive side, the signs of general deterioration of the blood; and on the negative side, the absence of lesion of the stomach.

This case proves that phosphorus does not always at least produce a local action in its poisonous influence, as is almost generally believed; for during life, in this example, there was no marked symptom of gastritis or gastro-enteritis present; nor, after death, were there found signs of inflammation, ulceration, or gangrene of the pharynx, œsophagus, stomach, or intestinal tube—appearances recorded in most text books, as found in cases of poisoning by phosphorus. The poison in the case now recorded seems to have exercised a general or constitutional influence, and the blood and the nervous system suffered chiefly, as evidenced by the symptoms and morbid appearances—the pain in the

breast and hypochondria, the state of vision, and the evolution of phosphorus by the sweat, are worthy of remark. With respect to the existence of albumen in the urine, and the signs of commencing Bright's disease, it is not likely that this condition was present before the reception of the phosphorus; for we find that the patient's health was excellent. It is much more probable that the lesion of the kidneys was produced directly by the poison, for the same has been observed in instances of poisoning by other agents, and moreover, it should be remembered how much the kidneys are exposed to injurious influences in the separation of noxious materials from the system. As to the duration of the case (something over four days) it is to be observed, that this is longer than that of previously reported cases; but it must be remembered that a great quantity of the phosphorous matches was rejected by vomiting, and that the poison was in the solid form, and covered with an envelope of gum. The fact of phosphorus not being detected after death, may be accounted for by the duration of the case, by the phosphorus remaining in the stomach being partly absorbed, and partly oxydised, and by the change which it underwent from the moment of death to the period of the examination.

It only remains to be mentioned, that the symptoms which are stated in different works to have been observed as the effect of phosphorus, and evidencing its stimulating or exciting property, such as erections, priapism, strangury, &c., &c., were not observed in the case which forms the subject of the present communication.—*Zeitschrift der k. k. Gesellschaft der Aerzte zu Wien.*

ON THE PROXIMATE CAUSE AND SPECIFIC REMEDY OF TUBERCULOSIS.

Abstract of a Paper laid before the Academy of Medicine of Paris on the 21st of July, 1857.

By JOHN FRANCIS CHURCHILL, M.D.

The total number of cases of Phthisis treated by me amounts to thirty-five. All were in either the second or the third stage of the complaint—that is, they had either softened tubercles or cavities in the lungs. Of these nine recovered completely, the physical signs of the disease disappearing altogether in eight out of that number; eleven improved considerably, and fourteen died; one still remains under treatment.

I believe that the results, of which the preceding is a summary, taken in connexion with the considerations I have set forth at length in the paper now in the hands of your Hon. Secretary, will be found to justify the following conclusions:

The proximate cause, or at all events an essential condition of the tubercular diathesis, is the decrease in the system of the phosphorus which it contains in an oxygenizable state.

The specific remedy of the disease consists in the use of a preparation of phosphorus, uniting the two conditions of being in such a state that it may be directly assimilated, and at the same time at the lowest possible degree of oxydation.

The hypophosphites of soda and lime are the combinations which hitherto seem best to fulfil these two requisites. They may be given in doses varying from ten grains to one drachm in the twenty-four hours. The highest dose which I have been in the habit of giving to adults is twenty grains.

The effect of these salts upon the tubercular diathesis is immediate, all the general symptoms of the disease disappearing with a rapidity which is really marvellous.

If the pathological deposit produced by the dyscrasy is of recent formation, if softening has only just set in and does not proceed too rapidly, the tubercles are absorbed and disappear; when the deposit has existed for a certain time, when the softening has attained a certain degree, it sometimes continues in spite of the treatment, and the issue of the disease then depends upon the anatomical condition of the local lesion, on its extent, and upon the existence or non-existence of complications. I have made numerous attempts to modify the local condition of the lungs by the inhalation of different substances, but have never obtained any satisfactory result independent of what was to be attributed to the specific treatment. The hypophosphites of soda and lime are strong prophylactics against tubercular disease.

The physiological effects which I have observed to be produced by the use of the hypophosphites of soda, lime, potash and ammonia, show these preparations to have a twofold action. On the one hand they increase the principle, whatever that may be, which constitutes nervous force; and on the other, they are the most powerful of hæmatogens, being infinitely superior to all medicines of that class hitherto known. They seem to possess in the highest degree all the therapeutical properties formerly attributed by different observers to phosphorus itself, without any of the danger which attends the use of that substance, and which has caused it to be almost forgotten as a medical agent. The different preparations of hypophosphorous acid will undoubtedly occupy one of the most important places in the *Materia Medica*.

The Academy resolved that the paper be referred to a Committee, consisting of MM. Louis, Trousseau, and Bouilland.

DEATH OF PROFESSOR COUPER.—The *North British Mail* announces the death of Dr. William Couper, Professor of Natural History in the Glasgow University, who died from natural decline, in his sixty-ninth year, at his residence, Lochbrae Cottage, near Kilpatrick. A few days prior to his demise the lamented deceased was seized with a severe attack of paralysis, which deprived him entirely of the use of one side.

Selections from Recent Contributions

TO

PHARMACY AND MATERIA MEDICA.

(Continued from page 159.)

Enema of Borax.—Arguing from the good effects of the local use of borax in aphthæ of the mouth, M. Bouchut proposes its employment, in the form of enema, in those cases of intestinal catarrh in children in which the mucous membrane becomes ulcerated around the anus. The formula he suggests consists of a drachm of borax to five ounces of a light decoction of pearl barley; this quantity of borax to be progressively increased to a drachm and a-half, or a little more.—*Bulletin Général de Thérapeutique*, tome 52, p. 216.

Mixture of Tannin in Chronic Bronchitis.—M. Berthel recommends the following mixture in cases of bronchitis of long standing:—Take of tannin, three grains; extract of belladonna, three quarters of a grain; extract of conium, two and a-half grains; infusion of senna, three ounces; fennel water and syrup of marshmallow, of each one ounce and a-half. Mix. A table-spoonful to be taken every two hours.—*Ibid.* p. 259.

On the preparation of Valerianate of Ammonia of definite composition.—This salt had hitherto not been obtained in a state of purity, and in the solid form. In fact, even in the most recent treatises on chemistry, the valerianate of ammonia is described as being liquid and amorphous; and the manufacturers of chemical products have been unable to supply it in a solid and crystallized state, pure, and of uniform composition. MM. Laboureur and Fontaine have endeavoured to overcome this difficulty. Their process consists in preparing pure valerianic acid and ammoniacal gas, and then uniting the two bodies. In proportion as the combination takes place the salt crystallizes in a confused form, but under the microscope, four-sided prisms, either terminated in pyramids or bevelled at their extremities, are distinctly seen. The valerianate thus obtained has been analyzed by a commission of the *Académie de Médecine*, and its purity has been ascertained.

The following is the formula.—Take monohydrated and pure valerianic acid; place it in thin layers in a flat capsule, covered with a perfectly fitting receiver; let anhydrous ammoniacal gas pass into the receiver, until the valerianic acid is saturated; preserve the valerianate of ammonia in small portions, in well-stopped bottles.—*Ibid.* p. 312.

On the preparation of the Subnitrate of Bismuth.—The subnitrate of bismuth is at present so much used in medicine, that it is well to study the chemical modifications it undergoes in traversing the digestive tube. It is rarely found in the fecal matters in the same state in which it has been administered. The causes of this are due, not only to the chemical reactions it undergoes in the stomach, but especially to the manner in which it is prepared. The manufacturers of chemical products, in fact, never supply the subnitrate of bismuth perfectly washed; it almost always contains an excess of nitric acid, and a soluble nitrate. This may be ascertained in the following manner.—Rub 100 grammes of subnitrate of bismuth with double its weight of boiling distilled water; when the mixture is cold, filter through paper. The filtered fluid has a styptic taste, and strongly reddens litmus paper.

If it be desired to determine with precision the quantity of soluble salt contained in the subnitrate, the latter must be washed with hot water until the filtered liquid is tasteless, and without action on test paper. The fluid is then evaporated in a porcelain capsule, until it is reduced by one-third of its volume. When it is cold, a solution of carbonate of potash is added, until the disengagement of carbonic acid ceases, and until litmus paper is unaffected by the solution.

On mixing the two liquids, the fluid becomes turbid; the potash unites with the nitric acid, forming a soluble nitrate and an insoluble oxide of bismuth, which is separated by filtration and washing.

This experiment will enable us to ascertain—from the weight of the oxide of bismuth obtained and that of the carbonate of potash employed—the quantities of nitric acid in excess, and of soluble nitrate contained in a specimen of subnitrate of bismuth.

It would be interesting to solve the following questions—the practical physician alone can answer them.

1. Ought the subnitrate of bismuth, in order to be a good therapeutic agent, to be chemically pure?

2. Ought this salt to contain an excess of nitric acid and a soluble nitrate.

3. Is it on account of the presence of the above-mentioned bodies that the subnitrate of bismuth is considered by some physicians to be a very good medicine; while other practitioners, on the contrary, prefer the carbonate of the same base.—*Ibid.* p. 364.

Formula for a Liquor Cinchonæ to replace the Wine of Bark.—M. Deschamps proposes the following—Alcohol, s. g. 833, five ounces; water, twenty-seven ounces; sulphuric acid, s. g. 1845, fifteen and a-half grains; yellow bark, three ounces; orange-peel, four scruples. Macerate the entire for ten days, strain, and add to the strained liquor half its weight of sugar; dissolve the sugar, and strain. One ounce represents the infusion of half a drachm of bark.

The advantages of the preparation are said to be—that while it is comparatively cheaper than wine of bark, the sugar it contains will modify its action in the same manner as the organic matter contained in wine does; secondly, that its taste is more agreeable than that of wine of bark; thirdly, that the preparation will always be uniform; and fourthly, that children will not refuse to take it.—*Ibid.* p. 417.

Pills and Tincture of Digitalis Seeds.—The pharmacists of small localities have not always time to prepare digitaline, or to ascertain the purity of what they buy. In order to be certain of having a product which is always efficacious, M. Brossard, a pharmacien of Rouen, proposes to gather the seed of digitalis, which keeps well from one year to another. Fifteen and a-half grains of this seed, pounded with a sufficient quantity of honey, affords a mass which, divided into thirty pills, contains a little more than a milligramme [0.015432 of a grain in each pill.] This pharmacien also prepares a tincture according to the following formula.—Digitalis seed, one ounce and seven scruples; alcohol, s. g. 852, four ounces. Macerate for eight days, and finally digest for two hours; then place the entire in a percolator; when as much as possible of the tincture has passed into the receiver, add to the residue alcohol in sufficient quantity to displace the last portions, so as to obtain four ounces. This tincture contains nearly one centigramme of digitaline in each gramme, [0.1728 of a grain to a drachm], and may be employed in mixtures, and in the preparation of syrup of digitalis.

M. Bouchardat, in publishing M. Brossard's note in his *Répertoire de Pharmacie*, while he admits that the seeds of digitalis vary less than the leaves in the proportion of digitaline they contain, justly remarks that a pharmacien should not, in any case, substitute a preparation of digitalis seeds for digitaline. But there is no objection to practitioners profiting from the instruction afforded them, and substituting in their prescriptions the powder of the seeds for that of the leaves of digitalis, as it is more active.—*Ibid.* p. 547.

Various formula for the gelatinization of Cod-liver Oil.—M. Stanislas Martin's Jelly modified.—Take of Cod-liver oil, two ounces; fresh spermaceti, two and a-

half drachms; simple or other suitable syrup, and Jamaica rum, of each six drachms. Beat the ingredients together with the aid of heat, and when the mixture has acquired some consistence, pour it into a wide-mouthed bottle.

Cod-liver Oil solidified with gelatine.—Take of pure gelatine, half an ounce; water, simple syrup, of each four ounces; cod-liver oil, eight ounces; aromatic essence, as much as may be sufficient. Dissolve the gelatine in the boiling water, and add successively the syrup, the oil, and the aromatic essence; place the vessel containing the entire in a bath of cold water; whip the jelly for five minutes at most, and then pour it, while still fluid, into a wide-mouthed glass bottle, furnished with a cork, or with a pewter cap, or if a bottle be not at hand, into a porcelain or earthenware pot, which should be carefully closed.

Cod-liver Oil gelatinized with Carrageen or Irish Moss.—Take of fucus crispus, half an ounce; water, eighteen ounces; simple syrup, four ounces; cod-liver oil, eight ounces; any aromatic, according to taste. Boil the carrageen in the water for twenty minutes; pass the decoction through flannel; concentrate it until it is reduced to four ounces by weight; add the syrup, the oil, and the aromatic; whip the mixture briskly, having first placed it in a cold bath, and pour it, while still a little warm, into the vessel intended to receive it. The syrup may be replaced by an equal quantity of Garus' elixir, mist or vanilla cream or rum, &c.

M. Sauvan proposes to combine cod-liver oil with Iceland moss. **Lichen and Cod-liver Oil.**—Take of Iceland moss jelly, four ounces; gelatine, four scruples; hydrocyanated cod-liver oil, (to which two drops of essence of bitter almonds have been added), six drachms. Prepare the Iceland moss jelly in the usual manner; melt the gelatine and pass it into the vessel which is to hold it; then add the cod-liver oil: stir the entire with a spatula, until the mixture be homogeneous and the jelly begins to congeal. Dose—two or three spoonfuls daily.—*Ibid.* p. 548.

Caustic Glycerine in Lupus.—The following formula is employed by Dr. Hébra, of Vienna.—Iodine, iodide of potassium, of each one drachm; glycerine, two drachms. This is applied every second day by means of a brush: it produces pain which lasts for more than two hours; but it possesses the great advantage of curing lupus without giving rise to disfiguring cicatrices.—*Ibid.* p. 549.

Re-agent for detecting the smallest quantity of Salimite mixed with Calomel.—M. Marchandier says:—“The purity of calomel is a matter of so great importance, that I think it useful to point out to practitioners a very simple process for ascertaining if the medicine is or is not free from the admixture of corrosive sublimate. The formula of my re-agent is—Iodide of potassium, one grain and a half; distilled water, two and a-half drachms; dissolve. About eight grains of calomel should be made into a paste with a drop or two of the test fluid on a bit of glass. If the calomel is pure, it acquires a green colour; if it contain but a thousandth part of bichloride, red spots are produced.—*Ibid.* p. 548.

New mode of preparing Mercurial Ointment.—M. Coldefier, of Geneva, proposes to facilitate the preparation of mercurial ointment, by employing ozonized lard in its manufacture. The following is his process. Sixteen ounces of lard, perforated with holes so as to increase the surface, are placed in a large porcelain capsule, while above the lard is suspended, on a string, a vessel containing half an ounce of phosphorus; the entire is covered with a glass bell, and at the end of fifteen hours, ozonization is completed. The lard thus prepared is introduced into a wide-mouthed bottle, and is melted in a sand bath, at a temperature of 194° F. Four ounces of mercury are then slightly heated, and rapidly poured into the lard; both are shaken together for some minutes, and the operation is terminated by plunging the bottle suddenly into a vessel of cold water.—*L'Echo Médical*, 31st July, 1857, p. 378.

* I have interpolated the words “in each pill.” That this is, however, the meaning of the writer is evident from the strength assigned in the sequel to the tincture.—*REPORTER.*

BRITISH MEDICAL ASSOCIATION. NOTTINGHAM.

On Thursday morning the members of the Association breakfasted together at the Royal Exchange Rooms. At this gathering the members of the Medical Reform Committee were hastily summoned to discuss an important communication made to the President of the Council. This turned out to be a letter from the Hon. J. W. Cowper to Sir Charles Hastings, stating that the Government intended bringing in a Medical Reform Bill during the next session of Parliament. On the assembling of the members at half-past eleven, the letter was read, and a resolution, expressive of the gratification of the meeting, was moved by Dr. Sibson, and seconded by Dr. Lankester. Dr. Stewart moved a resolution, directing the Reform Committee to listen to no plan of Medical reform that allowed the Government an exclusive or predominating influence in the Council of Medical Education. After much discussion, this resolution was negatived, on the ground that it was an unnecessary direction to the Reform Committee. Dr. Robinson then read the address on Medicine. This address, which was very elegantly written, took up the subject of Sanitary Science, and embraced a history of sanitary arrangements in various parts of the world down to the present time. On the reassembling of the meeting in the afternoon, several papers were read. Mr. Henry Thompsoned off with a paper on strictures of the urethra. Mr. Hatton read a curious case of occlusion of the uterus after impregnation, in which it was necessary to make a crucial incision in the uterus, and to destroy the child, in order to effect delivery. Dr. Edward Smith read a paper on the effects of exercise on the respiratory movements. Dr. Sibson read a paper on aneurism of the aorta; and Sir Henry Cooper finished a case he had commenced in the *British Medical Journal*. Thanks were then voted to all parties—to the President, to the Mayor, the Town-council, local Secretaries and others. This terminated the business proceedings.

The dinner took place in the Royal Exchange Rooms. This meeting was not a very large one. Few members from the immediate towns were present. Perhaps the branch meeting recently held at Nottingham may account for this. But the objects of the Association were effected, members of the profession distant from one another were brought together, and important social and political questions were discussed. The determination to meet next year at Edinburgh was an important move. D. Alison was elected President; and should he not be able to fulfil the duties of the chair, there can be little doubt that the Association will be well received in Scotland, and lay the foundations of its extension in the North.—*Medical Times and Gazette*.

THE influence exercised by the French Academy of Medicine is far greater than that possessed by any of our scattered societies for the discussion of professional matters. This gives proportionate interest to those elaborate debates on important and momentous topics which from time to time occupy the attention of the Academy, a whole month being sometimes devoted to the thorough investigation of a simple subject. Last week was concluded a long and spirited debate, which had extended over several *séances*, on the important subject of administering anaesthetics, or, as our French neighbours call it, etherization. M. Devergie, whose name is so well known in connexion with medical jurisprudence, had some qualms of conscience in regard to the responsibility incurred by medical men in cases of death during the administration of chloroform. These he submitted to the consideration of the Academy. Evidently believing that asphyxia is the general cause of death in such cases, he urged the absolute necessity of employing an apparatus for inhalation which should

provide a definite admixture of air with the vapour; and this last question became the most prominent one in the debate. M. Velpeau stated that he had administered chloroform three or four thousand times in ten years without an accident; and M. Huguet mentioned that only one medical man in Paris employed any mechanical contrivance for inhalation. The general opinion of the Academy seemed decidedly opposed to the deductions of M. Devergie as to the general cause of death, the advisability of using an apparatus, the necessity of definitely restricting the dose administered, and the propriety of rendering the medical man responsible in case of accident. The debate was finally closed by the Academy giving its assent to the following resolution, proposed, singularly enough, by M. Devergie himself:—"The Academy declares that, in the present state of science, etherization may be practised with or without apparatus; and that the choice of means should be left to the judgment of the physician or surgeon."—*The Lancet*.

A CASE of considerable interest, in a toxicological point of view, has just been tried, in which a man was accused of having poisoned his grandchild with a preparation of phosphorus. It was proved in the evidence that the mother of the child was sent by her father to procure some arsenic or ratbane at a chemist's shop in Truro, the usual pretext being alleged, namely, that it was to be obtained for the purpose of poisoning rats. The chemist, however, recommended another preparation, called *phosphor paste*, and he sold the woman a pot of this compound, which was said to contain between seven and eight grains of phosphorus. This paste was to be spread upon thin pieces of bread, and placed over the rat-holes. The deceased child was seen to be eating something, supposed to be the paste in question; and after some time had elapsed, was seized with pain in the stomach, vomiting, convulsions, and death. The post-mortem examination revealed very decided traces of inflammation in the stomach and bowels, and blisters were seen in certain parts. One portion of the intestine was invaginated, an appearance which has been seen in one similar case before, and which has been recorded in Dr. Taylor's well-known book on Poisons. The chemical evidence was unsatisfactory, as Mr. Herapath could not detect any phosphorus in the contents of the viscera of the child; but the difficulties of the detection will be readily appreciated when it is stated that the body had been buried nearly a month, and that the phosphorus may have passed into the state of phosphoric acid, which is one of the normal constituents of the human body. Mr. Herapath, moreover, although he tested the body for arsenic, antimony, mercury, copper, lead, strychnia, and other known irritant poisons, did not at first suspect the use of phosphorus, owing to the rarity of the cases in which that substance is employed as a poison. He analyzed the phosphorus paste, and found it to consist of five per cent. of phosphorus in a finely divided state, the remainder being starch, water, and colouring matter. The prisoner was acquitted, not because there seemed to be any reasonable doubt that the child died from the effects of phosphorus, but because the proof of administration was not complete.—*Medical Times and Gazette*.

DISCOVERY OF NATURAL GAS AT HULL.—On the 28th ult. an extraordinary phenomenon was witnessed in Crystal street, Hull, at the private residence and private waterworks of Mr. Thomas Stather, civil engineer. It was that of fire and water issuing at the same moment from the same fountain. Mr. Stather wished to sink a well, and for that purpose had engaged a large body of experienced men. Up to five o'clock on Monday afternoon the well-sinker had bored to the depth of forty-eight feet below the surface, and at forty-five to forty-eight feet had found a bed of peat, three feet thick, beneath which he came to a bed of gravel, containing broken flint and the remains of marine shell-fish. As the water now issued from the surface of the boring in a

bubbling fountain, varying in height from one to six or seven feet, and from that to ten feet, spouting out volumes of gravel and fine sand, the sinker, who had, in sinking other wells, previously seen something of the kind, though on a smaller scale, being certain that this was occasioned, not by the force of water, but of gas of some kind, determined to try whether it was inflammable, a thing which he had never in his life attempted before, and to his surprise there arose a lurid flame, two yards in height, issuing from a tube three inches in diameter, and through which tube the water continued to flow and boil over without at all diminishing the volume of flame, which ascended considerably higher than the garden wall, which is seven feet high. The flame was extinguished for the night for fear of alarming the neighbourhood. On Tuesday morning Mr. J. D. Sollitt, the chemist and lecturer, and head master of the Hull Grammar School, was brought to the spot in consequence of the discovery; and during the day Sir Henry Cooper, M.D., and other scientific gentlemen, also examined the extraordinary phenomenon. A tube three inches in diameter, and six feet high, was added to the one which was a few inches only above the ground, and the water and the gas still flowed freely together, but after a time the water ceased to rise so high, and gas only escaped. At ten o'clock on Tuesday morning Mr. Sollitt stated that the quantity of gas which had escaped the orifice—supposing it to have continued with the same force as he witnessed—would, from 5 o'clock on the preceding afternoon, have more than filled the largest gasometer at any of the gas works in Hull, and would, in fact, have been sufficient to light during the night all the streets in this town of 100,000 inhabitants. *Hull Packet.*

A CASE has just been decided in the House of Lords, by which the trustees of St. George's Hospital lose a legacy of £60,000. It seems that the late Earl Beauchamp bequeathed that sum for the foundation of almshouses at a place called Newland, a small hamlet with a population of two or three hundred persons; but he provided no site for the erection, and left the money only on condition that some one would furnish a site within twelve months of his decease, which a benevolent gentleman accordingly did. From the nature of the bequest, however, some legal difficulties arose, and it was determined by the Master of the Rolls and the Lords Justices that the appropriation of the money to the building of almshouses was illegal, and judgment was given to pay it over to the Trustees of St. George's Hospital, a provision in the will having been made to that effect. The case was then carried to the House of Lords, where the judgment of the other Court was reversed, and the money was made to revert to its original destination.—*Medical Times and Gazette.*

We copy the following from the morning papers.—Mr. Wrigley, manager of the Richmond Lunatic Asylum, after a service of twenty-eight years in that establishment, has been superannuated, and will retire on the appointment of a successor. We understand that none but duly qualified practitioners in surgery and medicine are eligible to the office, and that a liberal salary will be allowed.

APOTHECARIES' HALL, DUBLIN.—At the annual meeting of the General Council, held, pursuant to Act of Parliament, at the Hall on the 1st of August, Dr. M'Munn, Governor, in the chair, the following officers were elected for the ensuing year:—Governor, Charles Henry Leet, M.D.; Deputy Governor, William Madden, M.D.; Directors and Examiners:—John Betty, M.D.; Edward H. Bolland, M.D.; Thos. Collins, M.R.C.S.E.; Charles Holmes, M.D.; John M'Munn, M.D.; William Madden, jun. M.D.; William D. Moore, A.B., M.B.; Robert Mulock, M.D.; Henry P. Nolan, M.D.; Jerome O'Flaherty, L.R.C.S.I.; George B. Owens, M.D.; Christopher Shaw, M.R.C.S.E.; John Shea, M.D.; Secretary, Dr. Leet.

APPOINTMENTS.

QUEEN'S COLLEGE, BELFAST.—The Professorship of *Materia Medica*, vacant by the death of Dr. Horatio Stewart, has been filled by the appointment of Dr. Seaton Read to the chair.

THE ARMY.

WAR OFFICE, JULY 30.

42nd Foot—Assistant Surgeon Alfred Hooper, from the Staff, to be Assistant Surgeon, vice M'Kinnon, resigned.

60th Foot—Assistant Surgeon Ebenezer John Hatchell, from the Staff, to be Assistant Surgeon, vice P. J. Hoey, whose removal from the Staff, as stated in the *Gazette* of the 22nd of May last, has been cancelled.

HOSPITAL STAFF.

Staff Surgeon of the First Class Thomas Fox, M.D., from half pay, to be Staff Surgeon of the First Class, vice John Gillespie Wood, placed on half pay.

Staff Surgeon of the First Class George Gordon Robertson, M.D., from half pay, to be Staff Surgeon of the First Class, vice Joshua Paynter, placed on half pay.

Acting Assistant Surgeon William Mitchell Treston, to be Assistant-Surgeon to the Forces, vice F. G. Pouliden, placed on half pay.

THE NAVY.

ADMIRALTY, AUGUST 4.

Surgeon John Joliffe to the Buzzard.

Acting Assistant Surgeons George H. Dyer to the Buzzard; Thomas S. Wilson and Huston Maxwell to the Impregnable, for Plymouth Hospital; Robert Purves, Anthony J. Fitzgerald, and Thomas Greese to the Victory, for Haslar Hospital.

THE ARMY.

WAR OFFICE, AUGUST 7.

Royal Artillery—Second Class Staff Surgeon John Duff, M.D., to be Surgeon.

14th Foot—Staff Surgeon of the Second Class George Smyth King, M.D., from half pay, to be Surgeon, vice Dwyer, deceased.

HOSPITAL STAFF.

To be Surgeons of the First Class—Staff Surgeon of the First Class George Anderson, from half pay. Staff Surgeon of the First Class William Denny, from half pay. Staff Surgeon of the First Class Patrick Gamble, from half pay. Staff Surgeon of the First Class William Carson, M.D., from half pay.

DEATH.

On the 11th instant, at 37, King's-road, Brighton, aged 67, Marshall Hall, Esq., M.D., F.R.S., Member of the Institute of France, &c.

COMMUNICATIONS have been received from Dr. Monro; Dr. Browne, Chatham; Mr. W. J. Johnson: A Subscriber; R. J. M.

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RICHMOND HOSPITAL.

CLINICAL REMARKS ON THE TREATMENT OF INTERNAL HÆMORRHOIDS.

By JOHN HAMILTON,

Surgeon to the Richmond Hospital.

FIRST PART.

The treatment of Internal Piles, which prolapse at stool, or which bleed, will vary according to the circumstances of each individual case, the extent of the prolapsus, the amount of the hæmorrhage, and the general health and habits of the patient.

If a person consults you on account of a very small protrusion, that returns of itself after the motion is passed, or is readily reduced by slight pressure, it may be a question whether you might not fairly try palliative treatment first, before resorting to any operative measures. It is remarkable what can be done in such cases, by enjoining exercise and temperance, in the indolent or luxurious, and by regulating the bowels by mild purgatives. A little of the ordinary electuary taken every night, softens the motion and prevents the pressure of hardened fæces in the hæmorrhoidal veins, or straining, both of which tend to keep up or increase that varicose-enlargement of the lower end of the veins, which mainly constitutes the hæmorrhoidal tumor. Another most important thing is, for the patient himself to inject, each morning after breakfast, a pint of cold water. If there is any hæmorrhage, a drachm of powdered alum may be added to the water. There are other cases also in which you would only use palliative means, although the prolapsus is more considerable, with some bleeding, but the latter not sufficient to reduce the usual health and strength—where, for instance, the patients were otherwise diseased.

Mr. S—, about seventy years old, had a very bad prolapsus of internal hæmorrhoids, which came down at stool, and remained down, very

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probably from his inaptitude in replacing it, for it could be easily reduced. But, besides his advanced age, he had bronchitis, and remarkably irregular action of the heart, with some swelling of the ankles. Any operation therefore was out of the question. He was recommended to use the truss suitable for such cases, with a conical box-wood pad, to keep the bowel up by its pressure, and prevent its descent when he walked. I saw this case in consultation with Dr. Moore, of Anne-street.

Mr. W—, aged 73, a thin, spare, and delicate man, with chronic rheumatic disease of the right knee, has hæmorrhoids, which prolapse, but only on the left side, forming an oblong red tumor.

The anus is relaxed, with loose pendulous folds of skin round it. The prolapsus takes place at stool, and remains down many hours after. Palliative treatment could alone be thought of here.

I saw another case of the kind with my friend Dr. Lees. A gentleman, 68 years old, a thin delicate man, who suffered from prolapsus, but chiefly complained of its fouling his linen. Dr. Lees, who was fully conversant with the extreme delicacy of this gentleman's constitution, agreed with me that no operative treatment could be contemplated.

But if a case presents itself, the patient being young or middle-aged, where the piles prolapse at stool, where they are slow to return, the anus so relaxed that there is a protrusion of a portion of the bowel on exercise or standing long, causing irritation and discharge which fouls the clothes and prevents horse exercise, and interferes with all the usual pursuits of business, or the enjoyments of life;—in such a case you will be expected to use decided measures of relief. This is still more imperative when the prolapsus is accompanied by such hæmorrhage from the piles as to impair seriously the patient's health and strength. When he is, like Dominick Dunbar, from the frequent and copious hæmorrhage, deadly pale, the pallor of a waxen hue, with lightness and giddiness of the head, noise in the ears, palpitation and dyspnoea on slight exertion, or even œdema of the

ankles and face, from a thin watery blood circulating in the vessels, it is a state most precarious, and which calls loudly for surgical interference. Take the following more minute detail of his case and the effect of treatment.

Prolapsing and Bleeding Piles, cured by Ligature and excision of the loose skin at the margin of the anus.

Dominick Dunbar, æt. 35, a teacher, formerly a man of most intemperate habits, admitted into No. 5 Ward, under Mr. Hamilton, January 23, 1856. He is thin and of a deadly pale complexion. He has suffered from prolapsing piles for three years, which have bled sometimes very profusely for the last two years. He thinks he sometimes loses half a pint of blood at stool, as if a vein were opened; so that he is reduced to the last degree of weakness. He has sometimes fainted after a motion, and once remained insensible four hours in the water-closet. He complains of thirst; his tongue is furred, and he is subject to rigors, to palpitation of the heart, and breathlessness on the least exertion; pulse 84, and the action and sounds of the heart normal. He has constant sense of weight at the anus; bowels generally constipated, with occasional attacks of diarrhœa. After straining at the night-chair, a large prolapsus of a purple colour comes into view, composed of numerous small tumors, some smooth on the surface, others, near the anus, rough, from numerous small holes or depressions, and others higher up, red and granular, like raspberries. It is easily reduced. Round the anus are many permanent folds of skin, very relaxed. When the piles are prolapsed the margin of the anus forms a roll round them.

January 29th.—Mr. Hamilton tied four of the piles, and removed three of the loose folds of skin at the margin of the anus. After this operation the patient had a rigor, and some difficulty in passing water, but his general health soon improved, and after an injection of tepid water, a large solid motion, nearly filling the chamber-pot, was passed,—evidently an old accumulation—with great relief. The blood entirely stopped, but there was still a very slight prolapsus at one side, and the anus still appeared lax, to relieve which Mr. Hamilton removed (February 20th) a loose fold at the margin of the anus, next to the prolapsus. This was quite effectual, and on the 4th of March he was discharged perfectly well. Fourteen months after he still continued well.

It is worthy of note that in this severe case the man had been twice operated on by the nitric acid, well and freely applied. It produced temporary benefit only, and he says he suffered more pain from it than from the ligature of the piles, and the removal of the flaps.

Let us briefly review the different means that have been used, with the object of preventing

the prolapsus of the internal piles, and stopping the bleeding from them. They are the application of the actual cautery; the nitric acid; caustic potash; the Vienna paste (composed of caustic potash, five parts, quick lime, six parts); or a modification of it, by M. Filhos, caustic potash, two parts, quick lime, one part; all of which destroy more or less of the surface or substance of the piles; removal of one or more of the piles by excision or the ligature; and the operation proposed by Mr. Hey (and recommended, with some modification by Dupuytren), of cutting away folds of integument quite close to the margin of the anus, which, by its subsequent contraction, will allow of no further prolapsus.

The actual cautery used to be resorted to formerly, but is rarely so now. I recollect a case in which Sir P. Crampton applied it. The patient, considerably past the middle period of life, had a very large protrusion, not only at stool, but when he walked, and it bled freely. It was thought the cautery would be less hazardous than the ligature, in a man whose constitution was a good deal impaired, and that it would cause a greater contraction of the relaxed parts. After three applications those expectations were realized, and he got well.

CASE OF SUPPURATION OF THE SPLEEN.

By CATHCART LEES, M.D.

Physician to the Meath Hospital, Lecturer on Practice of Medicine, &c.

A delicate-looking man, æt. 23, a labourer, much emaciated, has a large irregular-shaped tumor occupying the left hypochondriac and lumbar regions, and extending upwards laterally, as there is dulness on percussion up to the left axilla. That side appears bulged out, and is an inch larger than the right; but there is no obliteration of the intercostal spaces, no œdema of the side, or distended veins over that part; nor is there any displacement of the heart. There is slight dulness posteriorly, but respiration is audible all over that lung, feeble posteriorly and mixed with sibilant and sonorous râles, but puerile under the clavicle. The tumor feels hard, but is not tender, and he lies best on the right side. He states that he has been delicate for the last three years, with an occasional sense of soreness in the left side of the abdomen, and has gradually become weak and emaciated, but never had intermittent fever. He has never vomited blood, or passed any from the bowels, but is very subject to bleeding from the nose, often two or three times a-day. There is no ascites nor œdema of any part. His pulse is small and quick, but he is not subject to rigors or perspiration. He died quietly a few days after this report, and on examination the spleen was found enormously enlarged, and full of purulent matter enclosed in a cyst, formed by the obliterated parenchyma which

had been converted into fibrous tissue. The other viscera were sound.

I have considered this case worth recording, as suppuration of the spleen is seldom met with, and its symptoms are generally very obscure. I made the diagnosis of enlarged spleen from the physical signs alone, as there was nothing in the history of the case or in the symptoms, indicative of disease in that viscus, (or indeed of suppuration in any part,) unless we may regard the bleeding from the nose as such.

Dr. Morehead, in his recent valuable work, "Researches on Disease in India," vol. ii. p. 165, states that he never saw a case of abscess of the spleen, and Rokitsansky says, that "though inflammation of the spleen may occur as a primary affection, yet it is as rare as spontaneous primary inflammation of a vein, but as a secondary affection it is as frequent as a secondary phlebitis, being in fact identical with that process, and nothing more than the metamorphosis of an infected coagulum within the channels of a vascular ganglion."

ON PORRIGO FAVOSA—ITS TREATMENT AND LOCAL CHARACTER.

By Dr. W. FRAZER,

Licentiate, King and Queen's College of Physicians, and Lecturer on Botany and Natural History to the Carmichael School of Medicine.

The Vegetable Parasitic Diseases to which modern observation has shown man to be liable in common with other animals, and our knowledge of which has been gradually extending of late years in proportion to the care and number of microscopic observers engaged in their elucidation, contain no affection so fully recognised, or so amply described perhaps as *Porrigo Favosa*, the so termed "scald head" of former days; and the observations of Schonlein, the first discoverer of its true nature, have been followed by those of Remak, Lebert, Robin, and many others on the Continent, whilst Dr. Bennett, of Edinburgh, amongst ourselves, has published ample details of its history and character. I have nothing of importance to add to these admirable accounts, save that I have verified their leading statements by observation; but, whilst the history of the affection has been so fully worked out, its therapeutics still remain very imperfect, so that many excellent practitioners have strong doubts as to the curability of the disease. I do not mean its temporary removal—this is extremely easy. I think simple poultices and various external applications, will not only take away the scabs, but keep them from reappearing for an indefinite time—perhaps as long as they are employed; and this has led, I believe, to the disease being considered permanently cured, when a relapse might be looked for on the patient's omitting his usual remedies.

I shall, therefore, briefly relate a case which seemed to me well suited for an experimental inquiry as to the best mode of treatment, so as to obtain its permanent removal and cure.

A young person in the better ranks of life, about twenty years of age, consulted me for a spot of *Porrigo* which had appeared on the inner part of the right thigh; it had been noticed very gradually increasing in extent for above four months, and was now about the size of a sixpence. I never saw a more perfect patch of the disease; it was elevated, and formed a cupped crust with depressed centre where I was led to think a hair had formerly existed, although none was now visible. It had the well-known yellow hue and peculiar mortar-like appearance of this affection; the edges of the skin around its base were slightly vascular. From its very circumscribed extent, I was induced to detach the scab, which I did with great ease, previously loosening its attachments to the cuticle around its circumference; it left a cup-shaped depression of soft and red derm, which discharged a pale reddish serum in small quantities, and its adhesions were chiefly at the edges where the disease affected the scales of the cuticle, and appeared to pass into them for a short distance. I examined the serum discharged under the microscope, and found in it a few blood globules and the true cells of the favus.

To the surface thus denuded, I applied most carefully a stick of *potassa fusa*, so as to produce a slough of very slight depth, and I took care to include the edges of the cuticle bordering on the depression in its effects; I previously removed two very thin and soft hairs which protruded through its lower part, and the slough detaching in about a week, left a clean granulating surface, in the discharge from which I could obtain no trace of the *Mycoderm*, although I examined for it more than once. It soon healed, and the cure has been perfect, for I have allowed upwards of a year to elapse since its occurrence before detailing the case.

The little mass of vegetation which was removed was examined, and its microscopic characters fully bore out my view of its nature; it consisted of a comparatively hard but friable external wall, from which, developing inwards towards the centre, ran multitudes of minute tubules (*thalli*), branching dichotomously and terminating in vast numbers of sporules which filled the centre of the crust with a fine yellow powder.

This case presents some points of interest; it occurred in a person far above the rank in life in which we usually meet *Porrigo*, for it is a disease rarely to be found except amongst the poorest and lowest classes. Its localization on the thigh is also very unusual; though the eruption is well known not to be confined to the scalp, still that is its most common seat, next in frequency to which we meet it perhaps upon the shoulder; nor do I

recollect another instance in which I have seen it on the thigh.

The very circumscribed extent of the disease, there being only a single spot attacked, led me to adopt the energetic means I did, of cauterizing for its removal; not that I think a far more extensive eruption would be any great objection to this mode of treatment, if carefully and judiciously applied, so as to produce perfect although *not over deep* sloughing of the surface whence the mycoderm grew and thus destroy its germs there. I consider this affords us decidedly the best chance of cure, nor do I see why in an extensive attack, the spots might not be treated in detail, applying the caustic over a few of them and repeating it on others at intervals, until all were removed. It has also this strong recommendation in its favour, that it is, as far as I know, the only means which will cure permanently, and it is neither tedious nor troublesome; with moderate caution I believe it to be quite free from danger, and I should think far safer than lotions of corrosive sublimate, or many of the ointments which have been recommended for this troublesome affection. Not that I have ever seen any bad consequences from these external applications, and I have now witnessed a great number of cases of Porriogo under treatment.

I believe it matters little whether we remove the Porriogo crusts by poultices before canterizing, or enucleate and separate them as I did; but I prefer my own plan for its rapidity, and as it avoids the scattering of the sporules, which in theory we might fancy to be liable to spread the eruption. However, I do not consider it of any great moment how we remove the crusts, so that they are got rid of, and the raw surface left for the application of the caustic potash.

Lastly, we have to consider the important question, as to the necessity of the so termed constitutional treatment of this and other epiphytic affections, and I must express my strong conviction that it is perfectly useless, and can have no action on the disease, nor can I believe otherwise, until I meet with some authentic case in which, whilst using internal remedies *alone*, the parasitic eruption has disappeared. I hold these affections as a rule to be "local" and not constitutional, and I do so after having spent much time and made many observations on them both in man and animals.

I think it would be as absurd to term an apple, an oak, or a moss a constitutional growth, as one of these lower fungi; and I do not conceive the fact at all proven that they either have or require peculiar soils for their growth; indeed, the strongest advocates for this view have been physicians accustomed to view diseases medically, and not over familiar with either the microscope or the natural history of our lower classes of plants; even should it hereafter be shown that a peculiar soil is indispensable for them, that I hold would not warrant our terming them constitutional any more than a difference in soil which gives the farmer

different crops, would entitle him to speak of his wheat or beet root, as being constitutional crops.

If these affections are amenable to constitutional treatment and to that alone, and if they are incurable by local means, then we may conclude they are of constitutional origin, but both of these remain to be demonstrated; on the other hand, if we can cure them perfectly by topical applications, independent of internal remedies, that alone would go far to establish their local character.

CASE OF ASIATIC CHOLERA.

By Dr. ROBERT MACDERMOTT.

I was called on Sunday, 16th August, to visit a man named Cunningham, aged 45, a porter in a mercantile house in Dublin, who had been attacked upon the previous evening with vomiting, purging, and cramps. Before leaving home I received a second message, saying that he was a great deal better, and that there was no necessity for my putting myself to any inconvenience, as all the distressing symptoms had subsided. This circumstance raised a suspicion in my mind as to the real nature of the case, and I immediately proceeded to the man's residence in Lower Rutland-street. I found him in the stage of collapse; pulse gone at the wrist; the body shrunk and cold; the skin a deep leaden color; the eyes sunk and surrounded by a dark areola. The heart's action was very feeble—the second sound being quite inaudible. Pressure upon the inside of the lip produced no change of colour. He was very deaf and almost blind; his voice was weak and stridulous, and he complained of vertigo and burning thirst. He had passed no urine for fourteen hours. On inquiry I found that he had diarrhoea during Friday, which subsided, without treatment, on Saturday morning. On Saturday evening, at nine o'clock, vomiting, purging, and cramps set in, and lasted until nine the next morning: so that when I visited him at two, p.m., he had been five hours in the stage of collapse. The evacuations were of the kind known as rice-water. He had taken no medicine. A stimulant mixture had been sent from a medical establishment in the vicinity, but had not been administered. I ordered a grain of calomel, and two grains of aromatic powder, to be given every half hour; warm jars to the feet; sinapisms to the epigastrium and calves of the legs, to be repeated every twenty minutes; the intervals to be occupied in making diligent frictions, with a liniment composed of equal parts of liniment hydrarg: and spir: terebinth: into the axillary, iliac, and epigastric regions. He got small quantities of iced brandy and water occasionally.

On returning six hours later, I found him a shade better. The vomiting and purging had not returned; the pulse was perceptible, and the heart's action was a little fuller; but the tongue

and surface were still deadly cold. There had been slight cramps, and some tendency to perspiration; the kidneys had not acted. *Repr: omnia.*

In the morning, about nine o'clock, I visited him again. The skin was something warmer, and the blood disappeared a little on strong pressure against the gum and inner lip, but seemed quite unable to return. He was a little livelier, and complained less of thirst. Ischuria still complete. The hypogastrium presenting some suspicious fullness, I passed a catheter, but found no urine. As he had now taken upwards of thirty grains of calomel, I ordered it to be discontinued. The mercurial frictions were repeated; warm stupes to the lumbar regions; ammonia and camphor interually. At seven in the evening there was no change for the better, save that the pulse had improved in strength; ischuria still complete; the mercury had produced no effect. I now ordered two drachms of mercurial ointment to be passed into the rectum, and directed that he should take twenty minims of spirits of turpentine every half hour; warm stupes were still continued to the lumbar region. About three hours and a half later the kidneys began to act, and he passed nearly three pints of urine in the course of the evening. It was loaded with mercury in the state of chlorides, but deficient in urea. It did not coagulate with heat or nitric acid. From this moment he rapidly improved. Contrary to my expectations there was no secondary fever of any moment, and in five or six days more he was able to resume his occupation.

It would be, of course, idle to draw any conclusions from an isolated case, yet there are some points in the present which I think deserve attention.

First—This case had well-marked premonitory symptoms.

Second—Mercury seems to have produced no effect up to a certain point.

Third—He got no opium during the stage of collapse, to which circumstance chiefly I am induced to attribute his recovery.

Fourth—He bore the spirit of turpentine without vomiting or purging.

Fifth—When the kidneys did act, they excreted the mercury profusely.

I did not give him opium, as I felt convinced that he was labouring under profound cerebral congestion, to which a narcotic would only fatally contribute. Whether the turpentine was of any real service or not can only be determined by experience in similar cases, which I trust may be long denied to us.

THE INDIAN MUTINIES.—The following members of the profession have fallen victims in the mutinies of India:—Dr. Dropping, 54th Native Infantry; Dr. Dawson, Royal Artillery; Dr. Phillips, 3rd Light Cavalry.

ON THE PRESENCE OF ELASTIC PULMONARY FIBRES IN THE SPUTA OF PHTHISICAL PATIENTS,

AS CERTAIN SIGN OF THE EXISTENCE OF A VOMICA.

By J. L. C. SCHROEDER VAN DER KOLK,
Professor in the University of Utrecht.

Translated from the Dutch by

WILLIAM D. MOORE, A.B., M.B., T.C.D.,
Honorary Member of the Swedish Society of Physicians.

(Continued from page 246.)

When we consult the observations of other writers on this subject, it is strange that the presence of these fibres has not attracted more attention. Investigators in general seem to have given themselves more trouble, though unsuccessfully, to look for certain distinctions between mucus, pus, and tubercular matter, than to examine closely the several forms and peculiar occurrence of these elastic fibres; and I am greatly surprised that, although the latter have been observed by some writers, no one has given an exact representation of them as they variously occur in the sputa. Simon appears to be one of the first to mention their presence in the sputa of phthisical patients; but he says no more on the subject than that he has seen more or less numerous fat globules, and some very fine tubes or fibres ramifying like vessels; while the representation he gives of these fibres is so incorrect, as rather to give rise to the suspicion that something had been accidentally mixed with the sputa observed by him, than that he had seen real elastic fibres of the lungs.* The plate given by Simon, of the tissue and vessels of the lungs, appears to represent nothing else than epithelial cells and fat.† Gluge,‡ to my surprise, says he never met fibres in tubercular matter. The drawings given by Vogel, in his excellent *Icones Physiol. pat'h.*, Tab. xv., xvi., and xvii., are important, where he represents these elastic fibres, as they occur in tubercles, taken partially undissolved from the lungs of a dead body, very well, but perhaps on rather too large a scale. He does not, however, represent them as they occur in the sputa, where their form and direction are often very different from what they are in the pulmonary cells. Thus in the sputa they are often broken up into smaller portions; yet they always retain their peculiar distinctive marks. Vogel§ observes that the occurrence of such dead pulmonary fibres in the sputa, is an equally certain and important sign that tubercular destruction of the pulmonary tissue has already set in. He does not however say whether their occurrence is constant, or whether they may also be absent in the sputa of phthisical patients.

* Simon, *Med. Chem.* T. ii., p. 316, fig 18.

† l. c., p. 316, fig. 19.

‡ *Anat. microscop. Ueters.*, Heft 1, p. 21.

§ *Icones*, p. 67.

Buhlmann, too, speaks of these fibres, and says that we meet them with areolar tissue in the sputa, especially in phthisis laryngea, or also in a vomica; that, however, they there occur more rarely, because they form the deepest layers of the abscess, which do not separate so early, and that we can find them much more easily by scraping with a scalpel after death. When, however, they occur in the sputa, they are the most certain sign of a suppurative process. But it is, he adds, self-evident that we must often examine all parts very accurately, in order to find them; for, except in case of death of the lung, they occur extremely rarely. He says he has often found filaments of areolar tissue in syphilitic ulcers of the throat, and observes that we often meet them also in phthisical patients, especially when a tubercle has very rapidly softened and forms a spreading cavity.* He does not give a drawing of them. It is evident that he has confounded these elastic fibres with filaments of areolar tissue, which latter, however, appear to occur in the pulmonary cells in less number than the elastic fibres, and are easily distinguished from them, inasmuch as they become very transparent in acetic acid. The elastic fibres in the pulmonary cells, are, as we shall hereafter endeavour to show, separated from the cavity of the cells only by an extremely thin and weak membrane.

Lebert also speaks of these elastic fibres, and says that we sometimes in the sputa of phthisical patients meet very well marked pulmonary fibres; and that this is not unusually the case when there are cavities. That, consequently, their presence is an important aid in diagnosis; that they possess so peculiar a form that they can be confounded with no other fibres, particularly not with those of the trachea, which might occur therein; that as these pulmonary fibres can occur in the sputa only when the pulmonary tissue is ulcerated with tubercular matter, they afford an infallible sign of the existence of cavities (*cavernes*). He, however, also states that the elements of tuberculous sputa possess no specific character, and that it is only in some cases that the pulmonary fibres indicate the presence of tubercles; whence he infers that we are constrained to admit that the microscopic examination of the products of expectoration in phthisis contributes nothing to the elucidation of the diagnosis, especially when the case is one of incipient phthisis. But if the disease be confirmed, it is evident, he says, that the sputa lose their value in this respect, inasmuch as other physical and rational signs then exist, which enable us to establish the diagnosis.† He does not delineate these fibres as they occur in the sputa; but he gives a drawing of them as they are met with in a tubercle taken out of the lungs,‡ which drawing is, however, less characteristic than that given by Vogel.

* Buhlmann, l. c., p. 64 et seq.

† Lebert, l. c. T. I., p. 413.

‡ Lebert, l. c., pl. viii., fig 11, B.

Rainey,* in his recently published beautiful essay on the minute structure of the pulmonary cells, and the formation of tubercle, makes no mention of the elastic fibres in sputa. He merely says that the expectoration is in great part derived from the mucous membrane of the bronchial ramifications, and very probably cannot be distinguished from that in an ordinary case of bronchitis; but he believes that when the tuberculous matter is dissolved and expectorated, it can be with certainty recognised by no other sign than the debris of the membrane internally investing the cells.

From the foregoing it appears, that of all the signs in phthisical sputa of the existence of a vomica, none remains except the presence of elastic fibres when these appear. The question therefore is: do these occur with sufficient regularity to serve as a certain indication of the existence of a vomica?

That they are by no means of such rare occurrence as several writers state, I have convinced myself from my own observations, inasmuch as after I had once discovered them, I have never missed them in any sputa of a phthisical patient, and I have constantly found them in greater or less quantity. The question is, therefore: do these fibres occur only when phthisis is already far advanced, and has produced great destruction; or are they present in the sputa from the first formation of the vomica, so as to indicate with certainty the existence of a vomica from its very commencement?

On this important subject I believe I may express my conviction, that, as I shall endeavour to show, these elastic fibres exhibit themselves in the greatest quantity precisely in the beginning of phthisis, and in the first formation of a vomica, and that they belong to the most certain signs we possess of the presence of a vomica. Subsequently, when the vomica has increased to a considerable cavity, they usually occur more sparingly and less distinctly in the sputa, and this appears to me to be one of the principal reasons why many writers have either not observed these fibres, or have taken but little notice of their presence.

This struck me particularly in the case of a young man of phthisical disposition, who had for more than a year suffered from a severe catarrh, and to whom I was this summer called in consultation. On the first examination I made I was soon convinced of the existence of an inflammatory process in the lungs; the pulse was usually above 100 in the minute; the cough was very severe; the sputa were more or less red coloured and globular, though for the most part floating; bodily exercise, as well as continued speaking, excited

* G. Rainey, on the Minute Structure of the Lungs, and on the formation of Pulmonary Tubercle, in *Medico-Chirurgical Transactions*. London, 1845, vol. xxviii., p. 596.

the cough; night sweats began to increase from time to time, and on any great excitement the peculiar flush appeared upon the cheeks. Occasionally he complained of some pain in the right side between the seventh and eighth ribs. On as accurate as possible, and repeated examination, the ordinary respiratory murmur was distinctly heard in both lungs; percussion yielded a particularly dull sound nowhere except pretty low between the seventh and eighth ribs on the right side. On the application, however, of leeches, and of an issue to the affected part, these inflammatory phenomena, probably the consequence of a slight pleuritic affection in that situation, with a severe bronchitis in the finer pulmonary ramifications, disappeared; the dulness on percussion in the part became less, and after a repetition of the leeches altogether ceased; deep respiration became entirely free; and under the use of cod-liver oil, with pills containing extract of *lactuca virosa*, the phenomena began so far to improve that the nightly perspirations were completely checked, the cough diminished, and the pulse finally returned to about 80. The expectoration of globular and occasionally red coloured sputa, however, continued, though in diminished quantity. After a couple of months the cough began to be more violent, in consequence of renewed colds and an attack of catarrh; the sputa again acquired a less favourable aspect, and in great part sank in water, and the pulse once more became quicker. The examination of the chest now showed that between the second and third ribs of the right side the sound on percussion was somewhat duller; no pectoriloquy could, however, be discovered; mucous râle alone was heard, and that with difficulty. Leeches were now again applied, and the issue was moved from below up to the more affected part. Now, for the first time, examining the sputa under the microscope, I found the pulmonary fibres above described in tolerably large quantity, which still further convinced me of the danger the patient was in; however, under the treatment, all the phenomena again diminished, the pulse sank once more to 80, the cough became easier, and the inflammatory symptoms decreased. But as the sputa continued pretty copious, I gave twice a day, in addition to the other remedies, and the occasional daily use of flax-seed tea, lime-water and milk; this the patient bore very well, and soon after the quantity of expectoration began remarkably to diminish, the nightly perspiration entirely ceased, the cough lessened, deep inspiration was unattended with inconvenience, and exercise produced less violent coughing. I requested a friend, a very experienced auscultator at ———, to examine the patient accurately, during a short stay there, particularly as he had seen him a year before, and had then found his chest to be in a perfectly normal condition. I shortly after, in the beginning of December, 1845, received the following answer:—"In consequence of your request that I

should communicate to you the results of my examination of the patient, I have examined him during his stay here. My first and principal object was to ascertain for you the phenomena observable on percussion and auscultation. Both sides of the chest appeared to me to be equal in form and circumference; percussion on the left side presented no abnormality; the right side was not so easily examined by percussion (on account of the issue). I have, however, so far as was possible, without putting the patient to pain, percussed the entire of the thorax, including the seat of the issue. Though I paid the greatest possible attention I could not discover any dulness; I can at least positively assert, that the sound in the supra-clavicular region was normal. Whether a dull sound should have been heard if the seat of the issue had been struck harder, I cannot decide. On auscultation the respiratory murmur was normal, both anteriorly and posteriorly. On neither side of the chest could anything pathological be discovered posteriorly, while the respiration was suspended. The heart's impulse was not transmitted farther or with more force through the pulmonary tissue, than is the case in healthy individuals. At the seat of the issue I immediately found the râle described by you. The sound was unmistakable, and was circumscribed in a small space as a mucous râle. I need not say that I did not confine my examination to what I have here communicated, but I wish, in one word, to add, that the form, colour, and quantity of the sputa appeared to me only too decidedly to confirm the suspicion of the destruction of a portion of the lung.

"On the principal point, therefore, my examination gives no other result than yours. This result is in itself certainly not particularly satisfactory, as it affords every reason for assuming the presence of tubercular softening" (I had informed my friend of the existence of elastic fibres in the sputa). "If we, however, take into account the degree and extent of the local affection, the slight disturbance of the physiological function of the organ, and the favourable condition of the general system; if we, at the same time, recollect the slow progress of the disease, which probably now dates from a year and a half back; if we add to this, that some general phenomena had, in the space of time that he was under my care (above half a year—he had previously used no remedies of any importance), even taken a turn for the better, the prognosis will perhaps be somewhat more favourable. I recollect your expression on this point in your former letter, that tubercular softening, as small vomicae, heal more frequently than is usually supposed." Thus we not unfrequently find in the lungs cicatrices of small vomicae which had previously existed.

Hence, therefore, it appears certain that phthisis had in this case as yet made no great progress; all the phenomena of the disease were wanting except

the cough and the presence of elastic fibres in the sputa, and according to a report communicated to me some days previously by the same physician, the patient was in better condition and stronger than he had been a year before, although he still was thin. The so-called physical signs of phthisis, the results of percussion and auscultation, yielded nothing certain, and the mucous rônchus, although an unfavourable sign, is surely no proof of the existence of a vomica, as it is also often present in bronchitis when the bronchi are in any degree filled with mucus; nevertheless, exactly at this time, the quantity of elastic fibres visible in the sputa was excessively great, so that they spread continuously over the entire field of vision of the microscope. Since this time, under the continued use of the same remedies, the cough has very much lessened, the sputa have diminished in quantity, and the elastic fibres begin to be fewer in number, so that, in fact, the prognosis is now more favourable, particularly since the issue has been applied upon the affected part, and the use of lime-water was commenced. It, however, appears that where the physical signs yield uncertain results, and do not decidedly indicate the existence of a vomica, the presence of these pulmonary fibres in the sputa plainly prove that the process is not as yet wholly arrested, and that the wasting of the pulmonary tissue progresses, so that we might hence infer that this sign is really more certain than those afforded by auscultation and percussion, and that it is eminently worthy of the attention of physicians.

This will become still plainer if we add to the foregoing a remarkable case given by Buhlmann,* of a patient in whom the sputa were exactly like those of a phthisical person, and were very copious, so much so, that he brought up, with the greatest ease, whole spoonfuls of perfectly purulent fluid, just as if a considerable vomica had existed; at the same time, pectoriloquy, cavernous respiration, &c., were heard in the dilated bronchi; the microscope exhibited the most perfect and unmistakeable pus, and no doubt was entertained of the presence of a vomica, while dissection proved that no abnormality existed but dilatation of the bronchi, without either vomica or ulceration of the mucous membrane, consequently no elastic fibres could be found in this case.

* *l. c.*, p. 39.

THE MEETING OF GERMAN NATURALISTS AND PHYSICIANS AT BONN IN 1857.—Professors Noggerath and Kilian, as the managers of the thirty-third meeting of Naturalists and Physicians have just issued their invitation to the scientific world, announcing that the assembling commences on the 18th and terminates on the 24th September. They state that Bonn, not only on account of the beauty of its situation, but also its scientific appliances, is well deserving a visit; and they promise a hearty reception to every friend of science, come he from where he will. They undertake the providing accommodation at hotels or in lodgings for those who communicate with them previously to that effect.

ABSTRACTS FROM RECENT CONTRIBUTIONS TO SURGERY IN AMERICA.

Successful treatment of Hydrarthrosis of the Knee Joint, by puncture and injection of Iodine. By R. L. MACDONNELL, M.D., Surgeon to Saint Patrick's Hospital, Montreal, &c., &c.

The practice of treating hydrarthroses by puncture originated with French surgeons, and was advocated especially by Malgaigne; but as this plan frequently failed, Bonnet of Lyons was led to try the effects of injection with iodine. Subsequently Velpeau, Jobert, Leriche, and others, adopted the practice, and with success.

British writers almost universally condemn this method of treatment, more especially Professor Miller, Mr. Ferguson, and Mr. South. Mr. Erichsen* approves of the plan, though he has no experience of it himself.

Dr. Macdonnell has, he says, treated successfully five cases of hydrarthrosis of the knee joint by this method. He gives the reports of three.

Case 1.—A cooper, æt. 26.—The disease had affected the right knee for four years; for a year he had been unable to work at his trade, and could not walk except with the aid of a crutch and cane. The joint was increased four inches in circumference, and the swelling extended five inches up the thigh.

It was at first simply tapped, and a large bowlful of serous fluid was drawn off; wet bandages and splints were then applied; no inflammation followed; but from the second day the fluid began to re-accumulate, and on the twelfth day from the first operation the joint was again punctured, and then injected with iodine. Two drachms, diluted with the same quantity of tepid water, was used; bandages and splints were applied as before. On the next day there was some pain complained of, for which opium was given. In three days the pain ceased, and on the fourth day he was able to leave his bed. For some time after the operation

* Mr. Erichsen thus writes—"If these (the ordinary) means fail, we have a powerful means of cure at our command in the injection of the joint with tincture of iodine. This plan, a sufficiently bold one, has been much employed in Paris, by Jobert and Velpeau, and in Lyons by Bonnet. These surgeons use the tincture diluted with two or three parts of water. A small trocar is introduced into the joint, a moderate quantity of the iodine solution is thrown in, and after being left for a few minutes, allowed to escape. Inflammation of the joint, which is a necessary result of this procedure, comes on. This is then treated by ordinary antiphlogistic means, and according to the statements of the French surgeons, has in no case been followed by any serious consequences, but in several instances, by a complete cure, without ankylosis, a new and healthy action having been imprinted on the synovial membrane. This mode of treatment does not appear as yet to have met with much support in this country, yet it certainly deserves a trial, though it should not be lightly had recourse to, as it is evident that the induced inflammation might exceed the expected limits."—*Science and Art of Surgery.*

ration the affected limb remained weak, and yielded in walking; but subsequently it is asserted that he walked "without the least lameness." Four years had then elapsed from the operation, and the man had during this time been able to work at his trade.

Case 2 is very similar to the former.—This man was also a cooper, and had for four years been supported by a charitable institution, owing to his inability to work, from the useless state of his left knee. The joint was greatly enlarged, and cracked on motion.

He was operated on last April, as described in the former case. Subsequently "there was no swelling or pain in the joint, no fever, no uneasiness whatever." The wet bandages were continued for ten days, and then a starched bandage was applied. The use of the limb was regained, but the exact amount of recovery is not mentioned.

Case 3.—A carriage-maker, *æt.* 25.—The affection in the knee had existed for seven years. "No pain or swelling followed the operation, and, notwithstanding his cachectic appearance and bad constitution, the progress towards cure was uninterrupted by the occurrence of a single bad symptom."

Dr. Macdonnell strongly insists that the object of the operation is *not* to produce an acute arthritis, as Bonnet supposed, but that, as in hydrocele, the disease may be cured by modifying the diseased secreting action. The rule of Velpeau and Cabard is therefore, when possible, to be followed: "To procure in shut cavities, containing an effused fluid, an irritation which should be constantly adhesive and not purulent."

In conclusion, he only advises this treatment in simple uncomplicated hydrarthrosis, that has resisted all other remedies, and that has led to loss of the limb, and has prevented the patient earning a livelihood, and enfeebled his constitution by constant suffering."—*Montreal Medical Chronicle.*

Penetrating Wound of the Chest—Extensive Pleural Effusion—Iodine Injection—Recovery.
By Dr. GRANT, Ottawa.

Case.—A carter, *æt.* 24, in a drunken affray, was stabbed in several places with a sharp-pointed knife. One wound penetrated the pleura, opposite the fourth intercostal space on the right side. Symptoms of pleuritis followed, which were treated antiphlogistically. Three weeks afterwards effusion had taken place, and small quantities of pus escaped occasionally from the wound, which had not yet healed. On one occasion as much as a pint and a half of sero-pus thus escaped, with great relief to the dyspnoea. A month after the injury, hectic had become well developed, and pus flowed freely from the side. Having allowed as much as possible to escape, an iodine solution was injected into the pleural cavity, part of which

flowed out again. A sensation of heat in the side was alone complained of. No inflammation followed, and one week afterwards the patient "continued to improve with surprising rapidity," and the discharge lessened very much. Perfect recovery ensued, and the fistula soon afterwards healed up.

Dr. Grant was led to employ iodine injection in this case from the success which had attended similar cases. In eight cases where empyema had been thus treated, but one, he states, failed.—*Braithwaite's Retrospect*, vol. 31, p. 86.

Dr. Tuxtarens of Paris is said to have been especially successful.

Other parts as intimately connected with life as the pleura he observes have been also injected, and successfully. He instances the pericardium by M. Aran; the peritoneal sac of hernia to obtain a radical cure, by Velpeau, Jobert, Maisonneuve, Ricord, &c.; ovarian cysts, by Babinet of Paris, and subsequently by Simpson and others. As also the tunica vaginalis, by Mr. Martin; and large joints for the removal of effusions, by Bonnet of Lyons, &c.—*Montreal Medical Chronicle.*

The *New York Pathological Society*, if we may judge from its reports, appears to be very well supported. Many of the communications reported in the journals are of much interest. The following extract shows that *morbus coxae senilis* is not limited to the white races, and that a knowledge of its pathology is no longer confined to these countries.

"*Chronic Rheumatic Arthritis of Hip.*—Dr. F. M. Wright presented a specimen of this disease. The patient was an old coloured man, who for sixteen years before his death had been so lame as to be almost altogether unable to work, and at intervals suffered severe pain in the hip joint. He died from some other affection, and on examination after death the bones presented very clearly the marks characteristic of this disease, viz., enlargement and flattening of the head of the femur, absence of articular cartilage, and partial eburnation of the articular surface, with bony vegetations surrounding. Precisely corresponding changes had taken place in and around the acetabulum, together with ossification of its cotyloid ligament."

Rupture of the right Rectus Abdominis Muscle—Symptoms of Strangulated Hernia—Operation and Recovery. By S. B. RICHARDSON, M.D., Louisville, Kentucky.

The accident happened to an athletic young gentleman, *æt.* 28, in hopping over a narrow ditch. Immediately after this effort he was seized with acute persistent pain below and to the right of the umbilicus. At the moment he experienced a sensation like a *snap*, or the crack of a whip. On the following day there had been no action of the bowels, although a purgative had been given. The pain continued, and the stomach rejected

everything. An indistinct tumor was now (in consultation) discovered at the seat of the pain. The abdomen was generally tender. Twelve leeches were applied, and subsequently ica.

Third day.—Vomiting frequent, with constant nausea; bowels still confined.

It was now agreed not to delay longer an operation, "expecting, as most likely from the signs and symptoms present, that we should find a *strangulated ventral hernia*."

A crucial incision was made over the tumor; as the layers were divided the tumor became more apparent and more tense. "Expecting to find a hernial sac beneath, the *fascia profunda abdominis* (sheath of the rectus muscle?) was opened by the knife held horizontally; and so tense was this structure that it split in advance of the scalpel." This brought into view a large coagulum of blood, estimated at half a pound weight, occupying a large irregular cavity, and resting posteriorly upon the peritoneum and bowels. On turning out the coagula, the right rectus muscle, with the corresponding epigastric artery and veins, as well as the sheath of the muscle, were torn completely across, and their ends retracted and separated about two inches. One artery was twisted, none ligatured, and water dressing was applied.

On the next day another coagulum occupied the cavity of the wound, and there had been some oozing of blood. After dislodging this and dressing the wound afresh, matters went on very well. Five grains of calomel caused the bowels to act. Three weeks afterwards the wound was almost healed.—*American Journal of Medical Science*.

Bibliography.

"*Erfahrungen über die Therapie der Magenkrankheiten*." Von PROF. OPOLZER.

In the paper before us we find briefly recorded the experience of this highly distinguished physician on the subject of the remedial means employed in diseases of the stomach, functional and organic. Professor Oppolzer first refers to the difficulty of diagnosis of various diseased conditions to which the stomach is liable. The practical physician will often find it impossible to assign an organic cause to many derangements of the digestion which come under his notice; nevertheless it may be that such deviations from health as are evinced by slowness of the process of digestion, and the development of excessive quantities of acid and of air, are caused by organic changes which, in the present state of our knowledge, remain undetected. Who can tell what changes may occur in the peptic glands, or what disturbance of innervation, or what slight alteration in the blood may be present, which are capable of exercising an influence on the

quantity and quality of the gastric juice? The deviations from health of the gastric mucous membrane and of the epithelial cells are not as yet thoroughly explored, and still there cannot be a doubt but that from them disturbances of digestion proceed. Believing that diet, in the widest signification of the word, is of the greatest importance in the treatment of gastric diseases, Professor Oppolzer commences with giving his experience on that subject. To milk diet, "milchcur" as the most valuable dietetic plan, he assigns the first rank. He recommends in all cases cows' milk, and prefers sour milk to sweet milk or to buttermilk, because in it the kasein is finely divided, and consequently more easily digested. By many patients the sour milk is preferred in the shape of curd, and by some the curd is mixed in water and taken as drink. Sweet milk is generally taken plain, but it should be skimmed; if buttermilk is employed it should be previously passed through a sieve. In diseases of the stomach, particularly when vomiting of the ingesta prevails, the milk should be given at first in small quantities, a few teaspoons-full gradually increased as it is well borne. Sour milk may be taken in larger quantities than sweet; when the latter is administered it should be in small quantities, and often, to prevent the formation of large lumps of cheese. In a few instances pyrosis occurs during the milk treatment, but small doses of carbonate of magnesia removes it. In others diarrhoea presents itself, and in such cases, after the milk, a small dose of "pulvis concharum preparatarum" was given. In severe forms of gastric disease nothing but milk was allowed, especially when vomiting of an obstinate character was present. To some patients, with whom the milk seemed to agree well, a milk pap of groats or rice, or arrow-root, was also given; a few bore weak broth and the yolk of egg. The diseases in which the milk diet is recommended in an especial manner, are chronic inflammation of the stomach, erosions, perforating ulcers, the vomiting of pregnancy, the vomiting in uterine diseases, the vomiting often so obstinate towards the close of typhus, in hysteria, &c. In cancerous disease of the stomach the milk diet will often afford relief, and in some cases sour milk is the only nourishment which can be tolerated. In some few diseases of the stomach in which the milk diet did not agree, small balls of raw flesh were given, the patients generally taking them without difficulty, but occasionally this plan could not be put in practice in consequence of an insuperable repugnance on the part of the sick. In one case the exclusive use of cold food was tried with advantage; a man who suffered pain after eating warm food and subsequently vomited, but who had no uneasiness after cold food, was kept on cold meat for two months, at the termination of which time he was enabled to eat warm food without suffering any uneasiness. We frequently meet with persons of sedentary habits who labour under difficulty of digestion; after meals they feel a sens-

tion of weight in the stomach, they frequently complain of eructations with the odour of food which they have eaten many hours before, in addition to pyrosis, flatulence, distension of the bowels and irregularity. In such patients there is a disinclination to mental labour, the head being engaged also, even the amount of movement which cannot be avoided is disagreeable, and they would wish to lie down and sleep after meals.

The treatment adopted by Oppolzer for invalids presenting the group of symptoms alluded to, is to send them to the hills at a suitable season, and he finds that a pedestrian tour and the mountain air agree so well with them that they return with good digestion and improved looks. The author, after this reference to dietetic plans, turns to medicinal agents. He informs us that he is in the habit each year of sending patients labouring under gastric affections to the Bohemian baths, to Karlsbad, Marienbad and Franzensbad. From Karlsbad and Marienbad he has seen good effects in the stomach derangement of the gouty, which manifest itself by heartburn, eructations and often by cardialgia. Karlsbad is to be preferred when the gouty subjects are advanced in life and have been for years ailing; it is highly efficacious in cases in which gall stones or renal calculi are the foundation of the gastric disease. Marienbad answers better for younger men, with a tendency to obesity, and with constipation. For persons labouring under chronic affections of the stomach, and such as follow anæmia and uterine menorrhagia, Franzensbad is found the most useful. Patients labouring under diseases of the stomach which are allied to congestions or to hæmorrhages, should not resort to these baths. In ulceration of the stomach, Karlsbad is to be feared as likely to produce gastric hæmorrhage, while Marienbad and Franzensbad are injurious owing to the distension of the stomach by the development of gas. Professor Oppolzer frequently avails himself of heat and cold in his treatment of diseases of the stomach; iced water and small portions of ice are administered in inflammations of the mucous membrane and in gastric hæmorrhage; the vomitings which appertain to diseases of the kidneys, uterus and brain, are relieved or altogether removed by taking portions of ice; he recommends cold applications also, giving a caution at the same time that cold water should be used at first, the temperature being gradually reduced to the coldness of ice; for if we commence with the latter violent movements of the stomach and bowels may be produced, which in gastric hæmorrhage are calculated to be exceedingly injurious. Warm applications, viz., warm cloths, poultices and baths, were found useful in simple and sympathetic cardialgia; as irritants, flannel, rabbit and hare skin, the fur next the skin, were applied, also aromatic plasters and mustard sinapisms; the warm coverings by means of the first, were directed in cases in which there was a tendency to cardialgia in the colder months, the latter

were used in slight pain in the stomach, the consequence of chronic inflammation. The narcotics were found very useful in many cases of painful affections of the stomach, opium and its preparations particularly. In ulcer of the stomach, solid opium is to be preferred to the tincture; to patients who at the same time labour under obstinate constipation, belladonna or conium should be administered. When perforation of the stomach is threatened, opium is the best remedy, inasmuch as it arrests the peristaltic motion, and thus renders cicatrization possible, opium has also been found powerful in allaying the cardialgia and the chronic vomiting of the drunkard. Laurel water proved effectual in slight gastric pains and in gastric catarrh, and disturbed the digestion less than other narcotics. Emetics were had recourse to, under certain circumstances in cases of indigestion.

Purgatives are frequently necessary in diseases of the stomach; enemata, and in some cases aloes, which was found preferable to castor oil and senna.

In cardialgia, with inordinate secretion of acid, bismuth was given with good effect. Antacids were employed and found to relieve the distress caused by the presence of acid in large quantity, generally a consequence of the process of fermentation; they ought to be administered after meals when the pyrosis commences, if they are taken before eating they readily disturb digestion. In ulcers of the stomach of all sorts, Oppolzer prefers the carbonates of the earths to the alkalies, as they are less stimulating to the diseased surface. When diarrhoea occurs as the result of the secretion of acid in abundance, chalk is pre-eminently the best remedy. The importance of neutralizing the acid which is generated in the stomach of children especially, is dwelt upon; also in cases of tuberculosis, in diseases of the brain and uterus, in ulcers of the stomach and dilatation of the stomach, the result of pyloric narrowing, it is well to neutralize the acid, as it gives rise to much distress, and may even occasion softening of the stomach, which although generally an event occurring after death, still may take place during life, as is proved by the pneumothorax which has followed the perforation of the diaphragm. In softening of the stomach of infants at the breast, alkalies, chalk and vegetable astringents are the best remedies. In redundant secretion of acid and mucus, and in gastric hæmorrhage, the vegetable astringents, viz., tannin, extract of rhatanhia, extract of salicis, decoctum ligni camp: &c. were found advantageous. The saccharum saturni was efficacious in some cases, in which cold and other astringents failed; the dose was small in order to prevent vomiting, which has been caused by large doses. Nux vomica and ipecacuanha in small doses have been given in obstinate cases of difficult digestion, the time selected being shortly before meals—the result was satisfactory. In persons of lax fibre and who are anæmic and whose digestion is slow, and who are affected with chronic catarrh of the stomach, the following

bitters have been resorted to: *Herba centaurei minoris*, *gentiana*, ext. *cardui benedicti*, quassia, colombo, rhenm, &c. &c. In the anæmic some of the mild preparations of iron have been useful. An inflammatory state of the stomach contraindicates these remedies. Creasote has acted well in relieving the flatulence, the result of fermentation, and in the vomiting of Bright's disease it has also given relief. In states of the stomach in which eructations with the odour of rotten eggs occur, wood charcoal acts well, but as this often contains fragments which are irritating, the charcoal may be made from burned bread.

In chronic inflammation of the stomach, hydriodate of potash in small doses was efficacious.

Professor Oppelzer concludes his notice of the remedial means he has been in the habit of employing in gastric affections, by bearing testimony to the value of nitro-muriatic acid in diseased states of digestion, with oxalate of lime in the urine, having adopted the treatment suggested by Dr. Prout.—*Zeitschrift der Gesellschaft der Aerzte zu Wien*.

DEATH FROM AMYLENE.

In the *Medical Times and Gazette*, August 8th, Dr. Snow relates a second case of death from the effects of amylene, the first having been given by him in the number for the 18th of April, of the same journal. Dr. Snow is of opinion that death resulted in this, as in the former case, from the fatal action of amylene upon the nerves of the heart, producing paralysis of the organ; that death in fact commenced at the heart, and not by asphyxia as had been asserted by M. Duvergie. The length of time the patient continued to breathe is very remarkable, spontaneous inspirations being made for three quarters of an hour after the pulse had ceased to be discernable at the wrist. The subject of this melancholy accident was a young man 24 years of age, admitted into St. George's Hospital, to have a small epithelial tumor removed from the back, by Mr. Hawkins, some of a similar kind having been removed upon three occasions and under the influence of chloroform, without any unpleasant result. It appears that in the administration of amylene, care must be taken that the air the patient is breathing should not contain more than about fifteen per cent of the vapour. Now in the ordinary mode of administering chloroform in amylene, this cannot be regulated exactly, as the vapour is not mingled with the air by measure. In this case it appears that the patient took one or two inspirations of the vapour a little stronger than was intended, and hence the fatal result.

THE HEAT IN BELGIUM. Mr. T. Forster, of Brussels, writes:—"I have registered the weather, and find that the average heat of this summer has already no parallel, and indeed exceeds every other by at least seven

CASE OF POISONING BY PHOSPHORUS.

Translated by SAMUEL THOMSON, M.D., from the 'Journal de Medecine et de Chirurgie Pratiques.'

HYGIENIC (LUCIFER) MATCHES.—AMORPHOUS PHOSPHORUS.—Chemists have more than once called attention to the practice of using phosphoric matches, which are a constant occasion of disease to those who make them, a source of danger to every one, and a deplorable convenience to the crime of poisoning. It is now no longer arsenic that murder employs to reach the victim; there is always at hand phosphorus—a poison of sure effect, and scarcely leaving any traces behind, but such as are difficult to verify.

The judiciary lists every day acquaint us with fresh cases of poisoning by this substance, and afford proof, that criminals of every class know they have at hand a poison equally certain with arsenic and almost securing them impunity. The '*Droit*' of the 16th July, adds to the store the following remarkable instance.

A young widow had taken for her second husband a man of intellect so weak as to border upon idiotism, but who was possessed of some fortune. After the lapse of some months, she resolved to get rid of him and gave him an infusion of chemical matches. The unhappy man succumbed, indeed, after some hours of suffering; but the suddenness of the death, and certain imprudent discourse, aroused the attention of justice; a visitation was made, and the woman interrogated concerning the deceased. She gave some confused answers, and ended by relating, that she had caused a few chemical matches to be infused in water for the purpose of killing rats. She had on the morrow taken out the matches, and thrown them into the fire; but at the moment when she was about to mix the infusion with flour, she found she had none, and went out to procure it, leaving the vessel with the phosphoretted water. On her return, discovering the dish to be empty, she asked her husband what had become of the liquid it contained, and his answer was, that having spilled some wine he had drunk up the missing water.

The officers of justice could not give credit to this tale, coming forth the day after the victim's death, and the trial has clearly proved that she did administer to her husband an infusion of chemical matches with intent to kill him, and she has been condemned to hard labour for life.

Facts of this nature, as we have said, multiply from day to day; and it is full time authority should prohibit the use of those matches, as they can henceforth be replaced by another manufacture in every respect much to be preferred. There are already in the market, under the name of Hygienic Matches (*Allumettes Hygieniques*), a sort having in their composition red phosphorus, which is known not to be poisonous, and does not emit in ignition the suffocating odour that issues from the

ordinary phosphoric matches, and lastly is in no way dangerous to workmen preparing it. This red phosphorus being difficult to inflame, it was necessary it should be conjoined with chlorate of potash, which always rendered the explosion easy and unsafe. But a Swedish chemist has conceived the idea of separating the phosphorus and chlorate; dipping the matches in one substance, he spreads the other on the side of the box. When a match armed with amorphous phosphorus is rubbed against pasteboard thus prepared, deflagration instantly takes place, and the match is kindled; but it is impossible for this to happen if the match is rubbed anywhere else than on the side of the box. In consequence of this arrangement, the matches called hygienic may be suffered to pass into the hands of children, or of the evil-disposed, without our having apprehensions of fire. If we will only keep the box out of the hands of such persons, no rubbing can excite ignition. They can be made to emit fire by means of the box alone, and under no conditions can they be made serviceable to poisoning.

These matches have therefore an incontestable advantage over the others. Their use is in no wise disagreeable, and their price is insignificant. It is therefore desirable that their sale should be authorised to the entire exclusion of the others; for thus will society be delivered from a permanent cause of fire and crime, while, through the progress of chemical science, we have still means to obtain instantaneous fire, as effectual as those which we have enjoyed for several years by the other kind of phosphoric matches, against the use of which we shall not cease to be arrayed.—*From the Medical Circular.*

NOTICE OF DR. MARSHALL HALL'S LIFE.

THE DUBLIN HOSPITAL GAZETTE, of August 15, in common with every other medical journal of the same date, announced the death of this physician, whose name is familiar to us all in connexion with the physiology of the nervous system. Upon the 11th inst., at Brighton, died Dr. Marshall Hall, aged sixty-seven years. This celebrated physician was born at Basford, in Nottinghamshire, in the year 1790, from whence he proceeded to Edinburgh in the year 1809, to enter upon his medical studies. It was here, and from the teaching of the eminent men who shone in the university at that time, that he imbibed that ardent love of science which is exhibited in his various and extensive works, and which urged him on in discovery up to the very close of his life. He was not neglectful, while in Edinburgh, however, of the means of acquiring a sound practical knowledge of his profession; for we find him resident physician for two years in the infirmary, after he had taken his degree, which he did in 1812.

Having spent a year in visiting the Continent, Dr. Marshall Hall settled in Nottingham, from whence after about ten years he removed to London. While at Nottingham he produced his work on diagnosis, the importance of the accuracy of which was not as fully recognised then as it has been since. Also "Experiments upon loss of blood," in which he explains, for the first time, the difference which exists between inflammation and irritation of the nervous centres, hitherto confounded. Dr. Hall explained their essential difference, their distinct causes, and the opposite lines of treatment required for their relief. It was, however, to his discoveries in the hitherto unknown region of the physiology of the nervous centres that Marshall Hall gained his well-earned and extensive fame. He was the first to explain the reflex function of the spinal cord, and consequently to throw light upon many phenomena, both in health and in disease, not previously understood. The division of the nervous system into the cerebral, the true spinal, and the ganglionic, with the account of the special functions of each, belongs to him. In a notice of this sort, however, we cannot attempt to detail all that Marshall Hall did for the elucidation of nervous phenomena. It will, we believe, take many years before we fully appreciate the extent and value of his discoveries in this department. We must mention, however, his physiologic test for strychnine, by means of a frog immersed in a very delicate solution, as affording both a beautiful and conclusive proof of his own theory of the irritability of the nervous system being greatest in the animals whose blood is the coldest, as well as being a very accurate and practically useful test of the presence of a minute quantity of strychnine. While the disease which ended in his death—a stricture, with malignant ulceration of the œsophagus—was making life a burden, Marshall Hall gave to the world his "Method of recovering drowned persons," which has already been the means of saving many apparently beyond the power of ordinary means of resuscitation. He was an M.D. of Edinburgh, a fellow of the Royal Society, and a member of the Institute of France. He always maintained that the true physiologist would make the best and most successful physician, and treated with scorn and contempt the term of *practical men*, given to those who knew nothing of the structure and functions of the body they were engaged to treat, and only learned by an extensive experience. He has certainly given us a proof that a physiologist may be a successful physician, and has left to us an example of well-directed zeal and untiring energy in the pursuit of knowledge, which, when gained, his powerful mind ever turned to practical use. It will be long before the uses to be made of Marshall Hall's discoveries are fully known, but his name will ever stand high on the list of those who have advanced and adorned the school of Physiological Medicine.

OPHTHALMIC CONGRESS AT BRUSSELS.

This important meeting is to take place at Brussels, on Sept. 13th, 14th, 15th and 16th of this year, and it is expected that notable improvements in the treatment of affections of the eye will be introduced by means of mutual suggestions. The prospectus, as published by M. Warlomont, the secretary, runs thus :—

First Section.—I. A. The transmissibility of the so-called military purulent ophthalmia being admitted, can the exact mode of transmission be ascertained? B. What is the influence we can assign to granulations in this disease, and what is their nature? C. Is there a mode of treatment of military ophthalmia the superiority of which has been sanctioned by experience? D. What are the most efficacious measures to forestal the disease and prevent its propagation?

Second Section.—II. What influence has the invention of the ophthalmoscope had on the diagnosis and treatment of diseases of the eye? III. What are the agents that contribute to, or preside over, the accommodating powers of the eye? IV. A. Can the existence of specific ophthalmias be admitted in the present state of science? If so, what is the actual meaning of the term, and to how many kinds of ophthalmia is it applicable? B. Can the specificity of these affections be recognised by anatomical and physiological characters? C. Can a complete cure be obtained by simple topical applications, or does the affection always require a general treatment?

Third Section.—V. Has experience shown that certain forms of cataract may be cured without operation? If so, what are those forms, and what are the means that may be substituted for surgical interference? VI. Of what benefit is the occlusion of the lids in the treatment of diseases of the eye? What are the affections of that organ which render such occlusion desirable, and what is the best mode of obtaining it? VII. A. Is the existence of establishments specially devoted to the treatment of the diseases of the eye advantageous? B. If so, what requirements should such establishments fulfil.

AMYLENE CONDEMNED AT THE ACADEMIE DE MEDECINE.

M. Giralde's having recently sent a paper to the Academy, entitled "Clinical Study of Amylene," MM. Robert, Larrey, and Jobert formed the committee to which it was referred. In the report read on the 18th inst., M. Jobert details various experiments and observations he has since made with this substance, both with and without apparatus; and he comes to the conclusion that amylene exerts an energetic and dangerous influence. The statement that has been made, that it is less active than chloroform, is only true when it is administered in the open air, and is explained, he says, by the rapidity of its evaporation. If only a sponge be employed, there are only produced, after a period varying from nine to nineteen minutes, muscular agitation and acceleration of pulse, effects that ensue in from

five to seven minutes if the sponge be placed in a cone of pasteboard. If an apparatus be employed, however, amylene becomes a most energetic anæsthetic, the desired result occurring in two and often in one minute. The effects of this agent are the increase of the number of the pulse by thirty or forty, the modification of the color of the blood, and the perturbation of the nervous system, inducing insensibility, coma, and the abolition of the intellectual power. It is thus a toxic agent, acting simultaneously upon the vascular and nervous systems. M. Giralde does not advance sufficient proof that amylene is less dangerous than chloroform; and even M. Robert's proposition of employing it in certain exceptional cases is not admissible, inasmuch as amylene possesses the inconveniences, without the advantages, of chloroform. Chloroform does not, like amylene, deprive the blood of its red colour; and while chloroform depresses and renders the pulse slower, amylene quickens it, producing congestion of organs. Amylene is of difficult administration, while chloroform is easily given. Chloroform has furnished to M. Jobert the same satisfactory results at all ages, and he believes that it is not more injurious in infancy than at a later period. He proposed that the conclusions of the author in favour of amylene should not be received; but as the communication is interesting in other points, the thanks of the Academy should be returned for it.

M. Velpeau proposed a stronger condemnation of amylene on the part of the Academy; for from the experiments even of the reporter, it was evident that amylene is more difficult to manage, and more dangerous in its results. In the recent case of death from it, there were not the attenuating circumstances adduced for chloroform or ether, such as the want of skill or experience of the manipulator, since it was the inventor himself who directed the procedure. "I maintain that a substance which in so short a time, and in the hands of him who recommends it, is dangerous to such a point, that its employment ought not to be permitted; and I propose that the Academy formally reject it."

M. Larrey observed that he completely agreed with M. Velpeau, and he should have thought that M. Giralde, after having been present at Dr. Snow's last accident, would have somewhat modified his ideas on the subject.

M. Jobert added, that when amylene is administered on a sponge, anæsthesia sometimes cannot be produced for half or three-quarters of an hour. If Charrière's apparatus be employed, it is rapidly induced, but at the expense of serious accidents. It differs from chloroform in that the insensibility it induces is instantaneous and not progressive. It produces an important modification of the blood.—*Moniteur des Hôp.* No. 100.

MEDICAL RETURNS FROM THE BALTIC AND BLACK SEA FLEETS.—On Wednesday, 19th August, appeared a Parliamentary paper, containing some interesting details relative to the mortality in the Baltic and Black Sea fleets in the years 1854 and 1855. It is shown that the total mortality from all causes, in both fleets and in both years, amounted to 2029 deaths; of which 1574 were caused by disease, 228 by accidental injuries, suicide, and drowning, and 227 only by wounds received in action—a number extraordinarily low. The diseases most commonly prevalent in fleets and armies include three classes:—1. Those arising from privation and other work; 2. Those arising from endemic or climatic causes; 3. Those arising from the inhalation of the germ of infectious diseases. The deaths from diseases of the first class, including typhoid fever, scorbutic affections, dysentery, diarrhoea, and ulcer, were not numerous. The deaths from local or climatic causes were also few, for the crews of the ships were seldom exposed to miasmatic influences, and when they were landed in low swampy places, as in the Black Sea and the Sea of Azof, quinine was almost invariably given as a protective against fever, and offensive exhalations in the hold

of ships were got rid of by ventilation and the use of the solution of chloride of zinc. The mortality under the third head (infectious diseases) might indubitably have been lessened, it appearing that if the fleet in the Baltic had not anchored in Baro Sound during the summer of 1854, and if that in the Black Sea had shunned Baljick and Varna in July, August and September of the same year, the mortality from cholera would have been greatly reduced. Cholera, like small-pox, yellow fever, and other infectious diseases propagated by a specific animal poison elaborated within the human system, and thrown from it into the atmosphere, is generally destructive amongst numbers in proportion to the force or concentration of the exciting poison and the poverty of the vital fluids of the patients. The mortality from consumption is much greater in the army than in the navy. It appears that the proportion of wounds and injuries of all kinds to the 1,000 of mean force, was greater in the Baltic than in the Black Sea fleet; but the reverse was the case as regards the rates of mortality. In the former, the total number of deaths from all kinds of injuries and drowning was 135; of which 21 were from wounds in action, 5 from gun-shot wounds received during the infamous attack on the boat's crew at Hango, 57 from drowning, and 52 from falls from the rigging and other accidental hurts. In the Black Sea fleet, its total number of deaths from external violence and drowning was 286; of which 201 were killed in action, 40 were drowned, and 45 killed by external injuries. The medical evidence goes on to show that sailors are more liable to rheumatic attacks than soldiers, but this will only hold good so long as the latter are comfortably lodged in cantonments or barracks. There is no evidence to show that the climate or soil on the bald steppes of the Crimea had the least effect in producing any form of bowel complaint, although the accumulation of filth and the effluvia arising from decay of organic matters were doubtless injurious to the general health, and so predisposed the weak and anæmic to be attacked by various forms of disease. Affections of the liver and jaundice were more numerous in the Black than in the Baltic Sea, by as much as 9.3 exceeds 3.4, but the mortality for both was nearly identical. Defective or erroneous diet, in connexion, possibly, with peculiar states of the weather, would appear to be the inducing causes of these liver complaints. The proportional number of catarrhal attacks was greater in the Baltic fleet by as much as 277 exceeds 215. Cholera was far more rife in the Black than in the Baltic Sea, for there, in one ship alone, the mortality exceeded by about one-half the total mortality in the whole force of the Baltic fleet for two years. The mortality from pulmonary complaints and diseases of the air passages was nearly the same in both seas, but the proportion was greater in the Baltic. Fevers were more common in the Black Sea, and also more fatal; in the two years there were 1720 cases of continued and remitting fever, and 1722 of the intermittent or aguish type. The mortality from cerebral diseases in the Baltic fleet was the same as in civil life, but in the Black Sea it was greater, probably owing to the indulgence of the seamen in bad spirits.

THE AMERICAN QUARANTINE CONVENTION.—The following resolutions have been adopted:—1. That there are certain diseases which may be introduced into a community by foul vessels and cargoes, and diseased crews and passengers. 2. That of these diseases the most injurious are small-pox, and, under certain circumstances, typhus fever, cholera, and yellow fever. 3. That when the latter diseases are introduced in this manner, their action is limited to individuals coming within their immediate influence, and they cannot become epidemic unless there exist in the community circumstances which are calculated to produce such disease, independent of the importation. 4. That these circumstances consist in the vitiated state of the atmosphere from local causes, in connection with peculiar meteorological conditions.—5. That efficient sanitary measures, including quaran-

tine, will, in most cases, prevent the introduction of these diseases, and may at any rate, disarm them of their virulence, and prevent their extension when introduced. 6. That the present quarantine regulations in most of our states are insufficient to prevent the introduction of disease and are prejudicial to the interests of the community. Disease may be introduced—(1.) By a foul vessel, especially when measures are not taken to keep the hold free from stagnant and putrid bilge water, and more particularly when there exist in the hold droppings and drainings from putrescible matters, which are allowed to penetrate and remain underneath the timbers of the ship. (2.) By cargoes consisting in whole or in part of rags, cotton, or other light porous substances, shipped from ports at which any malignant epidemic or disease of a contagious and infectious nature prevailed at the time when the vessel was loaded. (3.) By the filthy bedding, baggage and clothing of emigrant passengers, particularly when they are crowded together in insufficient quarters, although the passengers themselves may be free from any actual disease. (4.) By the air that has been confined during the voyage in closely sealed and ill-ventilated holds. (5.) By squalid and diseased passengers, landed and crowded together in unhealthy neighbourhoods, or in small ill-ventilated dwellings. (6.) By passengers and crews who are actually labouring under, or infected with, any positively contagious disease; and by their bedding, clothing or baggage. The above resolutions were adopted by a vote eighteen in favour, two against, and one tie-vote.

THE MULBERRY-TREE AND THE SILKWORM.—From an interesting paper recently communicated to the Academy of Sciences by M. E. Guérin Ménéville, it appears that the existence of an epidemic disease of the mulberry-tree which has been denied, is now fully ascertained. M. Ménéville states from personal observation that the disease exists in Switzerland, and in all the departments of France through which he has passed on his way from the Basses Alpes to Spain. It produces numerous red spots on the leaves, which soon shrivel up and fall off early in June. This disease is not new, and single cases of it have been frequently observed; but this is the first time it has made its appearance under an epidemic form. It is most virulent in those districts where the silkworm has suffered most, and there is every reason to believe that it is one of the principal causes of the disease of that insect. The latter is now called the *gattine* in France, but it had been remarked before in solitary cases; the silkworms attacked with consumption have long been called *luzettes* in France, because they have a shining appearance, and do not grow. In the south of France they are called *arpians* and *passia*.

SALE OF POISONS BILL.—This bill, as amended by the select committee of the House of Lords, has been printed. The list of "poisons," defined as such, has been much reduced. It now includes arsenic and its compounds, corrosive sublimate (the bichloride of mercury) and its solutions, the poisonous vegetable alkaloïds and their salts, Prussic acid, the cyanide of potassium, the essential oil of bitter almonds, and mixtures containing it, cantharides, aconite and its preparations, opium (crude or in tincture, extract, or powder), chloroform, oxalic acid, and salt of sorrel, nux vomica (whence strychnine is derived), tartarized antimony and cocculus indicus. Poison must only be sold to a person of full age, in presence of a witness of full age, and upon the production of a certificate; and after 185—no poison can be sold without licence except by a regular medical practitioner. It appears, however, that poison may be sold to any person who is not unknown to the vendor.

PARIS ACADEMY OF MEDICINE.—The vacancy in the section of Natural History and Therapeutics has been filled up by the election of M. Moquin-Tandon by a large majority.

APPOINTMENTS.

THE ARMY.

WAR OFFICE, PALL-MALL, AUGUST 14.

1st Dragoon Guards—Assistant Surgeon Edward Louis McSheehy, from the Staff, to be Assistant Surgeon.

4th Light Dragoons—Surgeon Archibald Alexander, from the 7th Light Dragoons, to be Surgeon, vice Kendall, who exchanges.

7th Light Dragoons—To be Surgeon—Surgeon Henry Kendall, M.D., from the 4th Light Dragoons, vice Alexander, who exchanges. To be Assistant Surgeon—Assistant Surgeon George Monlas Slaughter, from the Staff.

Coldstream Guards—The Commission of Assistant Surgeon Francis Bowen, M.D., has been antedated to December 22, 1854.

44th Foot—Assistant Surgeon James Boyer Baker, from the Staff, to be Assistant Surgeon.

56th Foot—Assistant Surgeon James Parr, from the Staff, to be Assistant Surgeon.

66th Foot—Assistant Surgeon Nicholas Ffolliott, from the Staff, to be Assistant Surgeon.

69th Foot—Assistant Surgeon Clement Williams, from the Staff, to be Assistant Surgeon, vice Kellett, who exchanges.

72nd Foot—Assistant Surgeon George M'Gusty Carolan, from the Staff, to be Assistant Surgeon, vice Roberts, appointed to the 79th Foot; Assistant Surgeon Morgan Jones Jones, from the Staff, to be Assistant Surgeon.

HOSPITAL STAFF.

Assistant Surgeon Edward Young Kellett, from the 68th Foot, to be Assistant Surgeon to the Forces, vice Williams, who exchanges.

THE NAVY.

ADMIRALTY, AUGUST 14.

With reference to the notice which appeared in the *London Gazette* of the 11th instant, the following additional promotion, dated the 10th instant, has been made in consideration of the successful operations against the Chinese Junks and Fort, on 25th and 27th May, and 1st June last:—

To be Surgeon—James Gibson Thompson Forbes.

Assistant Surgeon to be Surgeon—James G. T. Forbes.

AUGUST 18.

Robert G. Clarke, Surgeon to the Nile convict ship; James George T. Forbes, Assistant Surgeon, to be Surgeon; Thomas Craig, Assistant Surgeon, to the Jasper; Thos. C. Hession, Assistant Surgeon, to ditto.

AUGUST 20.

Surgeon Edward Heath, to the Diadem; Assistant Surgeon John S. Adams, to the Diadem; Thomas M'Gahan, to the Victory; acting Assistant Surgeon Francis Green, to the Diadem.

AUGUST 26.

Surgeons—Hugh T. S. Beveridge, to the Conqueror; Andrew Murray, to the Valorous; James Wicher, to the Conflict; and Wm. Richardson, to the Styx.

Assistant Surgeons—P. Mansfield, to the Valorous; and Gilbert L. King, to the Impregnable.

Acting Assistant Surgeons—Thomas G. Wilson, to the Conflict; and H. Maxwell, to the Styx.

THE ARMY.

WAR OFFICE, PALL-MALL, AUGUST 28.

9th Light Dragoons—Assistant Surgeon Alexander Macrae, M.D., from the 53rd Foot, to be Assistant Surgeon, vice Clifford, promoted to the Staff.

5th Regiment of Foot—Assistant Surgeon Maximilian Grant, M.D., from the Staff, to be Assistant Surgeon.

32nd Foot—Assistant Surgeon William Henry Harris from the Staff, to be Assistant Surgeon, vice Cahill, promoted on the Staff.

37th Foot—Assistant Surgeon William Ramsay, M.D., from the Staff, to be Assistant Surgeon.

43rd Foot—Assistant Surgeon John James Henry, from the Staff, to be Assistant Surgeon, vice Duffin, deceased.

44th Foot—Assistant Surgeon Charles James Kinahan, from the Staff, to be Assistant Surgeon, vice Butler, appointed to the Staff.

53rd Foot—Assistant Surgeon Richard Hungerford, from the Staff, to be Assistant Surgeon, vice Macrae, appointed to the 9th Light Dragoons; Assistant Surgeon Robert Henry Beale, from the Staff, to be Assistant Surgeon, vice Grant, promoted on the Staff.

74th Foot—Assistant Surgeon George Peacock, M.D., from the Staff, to be Assistant Surgeon, vice Lapsley, promoted on the Staff.

HOSPITAL STAFF.

To be Staff Surgeons of the Second Class—Staff Surgeon of the Second Class Richard Valpy de Lisle, from half pay; Staff Surgeon of the Second Class Daniel John Doherty, from half pay; Staff Surgeon of the Second Class Thomas Park, from half pay; Staff Surgeon of the Second Class Charles Walter Poulton, from half pay, vice Doda, deceased; Assistant Surgeon John James Clifford, M.D., from the 9th Light Dragoons; Assistant Surgeon Alexander Peile Cahill, M.D., from 32nd Foot; Assistant Surgeon William Lapsley, from 74th Foot; Assistant Surgeon James Simpson Grant, from 53rd Foot.

To be Assistant Surgeons—Assistant Surgeon Richard Lewise Butler, from the 44th Foot, vice Kinahan, appointed to the 44th Foot; Acting Assistant Surgeon William Langford Farmer, vice Robertson, appointed to the Rifle Brigade; Robert Lewer, Gent., vice Storey, appointed to the Rifle Brigade; Edmund McGrath, Gent., vice Knipe, appointed to the 68th Foot; A. Chester, Gent., vice Sheehy, appointed to the 7th Foot; C. H. Browne, Gent., vice Davidson, appointed to the 1st Dragoon Guards; Thomas Rudd, M.D., vice Muschamp, appointed to the 82nd Foot; Thomas Sharkey, Gent., vice Finnemore, appointed to the Royal Artillery; Frederick Ffolliott, Gent., vice Marston, appointed to the Royal Artillery; William Henry Leslie, M.B., vice Dickinson, appointed to the Royal Artillery; George Samuel Burnside, Gent., vice Hepworth, appointed to the Royal Artillery; Andrew Mather Porteous, M.D., vice Fletcher, appointed to the Royal Artillery; Alexander Stevenson Russell, M.D., vice Forshall, appointed to the Royal Artillery; Assistant Surgeon Peter J. Hoey has been permitted to resign his commission.

Assistant Surgeon William Edward Wood, Bombay Army, to have the local rank of Surgeon in Persia, while employed on a mission to Herat.

Dr. George Armstrong has been appointed Medical Attendant to the Blackrock Dispensary, in the room of Mr. Le Clerc, appointed Surgeon to the Constabulary Force in Ireland.

COMMUNICATIONS have been received from Mr. Green, T. U., Dr. Johnson (Belfast), Dr. O'Connor, Mr. Evans, &c. &c.

BRITISH ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE.—In our next number we will commence a report of the proceedings of the British Association, as far as they are likely to be of interest to our readers.

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RICHMOND HOSPITAL.

CLINICAL REMARKS ON THE TREATMENT OF INTERNAL HÆMORRHOIDS.

By JOHN HAMILTON,

Surgeon to the Richmond Hospital.

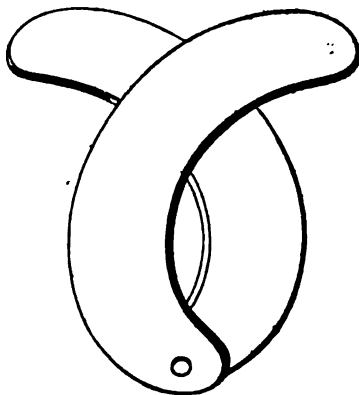
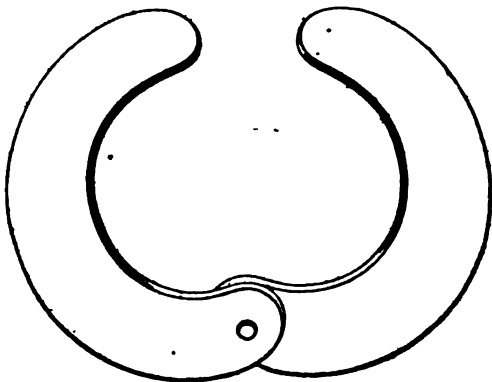
SECOND PART.

In France, some surgeons prefer to destroy the hæmorrhoids by caustics, and different instruments are used by them for the purpose. M. le Dr. Alphonse Amussat effects the application of the caustic of Filhos to the root of the hæmorrhoid by a very ingenious forceps the invention of his father, or one with a modification of his own.

The transverse arms of the branches of the forceps, which seize the pile at its base, have grooves in them that hold the caustic, which previously to the application is covered by a slide. When the pile is firmly compressed by the forceps and kept so by it, the slides are rotated back, and the uncovered caustic comes in contact with the sides of

the base of the tumor. The application is continued from two to four minutes, and during this time constant irrigation of the part with cold water is kept up by an assistant, and is continued afterwards, to wash away any of the particles of caustic that might remain; or this is more effectually accomplished by acidulating the water with a little vinegar. To those, however, who do not possess this ingeniously contrived forceps, a simple mode of proceeding is recommended, viz:—to seize the hæmorrhoidal tumor with the ordinary dressing or dissecting forceps, and cauterize it directly by applying to its centre a stick of Filhos' caustic pointed, and giving it a rotatory movement to penetrate the hæmorrhoid, so as to destroy it both centrally and laterally. The neighbouring parts should be protected with spatulæ, and the whole washed with acidulated water after the operation.

If you apply the caustic directly, you need not trouble yourselves to make Filhos' caustic, or the Vienna paste, as a stick of the common caustic potash is quite as good. A very simple but ingenious means for its safe application is this instrument, invented by M. Jobert de Lamballe.



This method of destroying prolapsing or bleeding hæmorrhoids, by destructive caustics, ought to be safe and effectual. I have had little experience of

it, but M. Amussat brings strong evidence in its favor.

A liquid caustic, which destroys much more su-

perficilly, the nitric acid, is a great favourite with many surgeons in Dublin, and some in London. Mr. Cusack, was, I believe, the first to use it; but the late Mr. Houston has the merit of having called particular attention to it by the publication of a number of favorable cases in the *Dublin Medical Journal*. Though successful in many instances and even in very severe ones, yet I do not place much reliance on it in the majority of cases of aggravated internal hæmorrhoids, the relief being often only temporary, and when much is attempted by a very free application of the strong acid, the effects are by no means so trifling as have been generally described—considerable inflammation of the lower end of the rectum and anus with œdematous swelling around the latter—hæmorrhage, from the acid causing a slough over a vein or artery—and severe pain, for many days after the application, of the surface burnt by the acid. The last effect was very troublesome in a case I saw with Dr. Brady, of Harcourt-street; the operation was effectual in a very aggravated case of prolapsing and bleeding piles, but the sufferings of the patient, from the raw surface left after the separation of some superficial sloughs, were extremely severe; from this raw surface also there may be more or less hæmorrhage.

Mr. W., fifty-three years of age, three years ago had the nitric acid applied for prolapsus and bleeding piles; the bleeding to such an extent that he was quite bleached. It required two applications of the acid. After this he continued well till some time since, when the bowel again came down at stool, or even when he walked a short distance; a roll of mucous membrane prolapsing on the left side, the size of the first joint of the thumb; it was red and excoriated on the surface, and at the most superficial edge, under the thin integument, large veins were very apparent. At stool the descent is much greater, two large livid tumors appear, raw on the surface and readily bleeding. He was in perfect health, but the annoyance of the prolapsus was very considerable.

May 6th.—As it was clear that a light application of the nitric acid would affect little in such a case, I applied it freely over all the surfaces till they were charred greyish-white; it gave pain when the surface was excoriated.

7th.—Some uneasiness about the lower part of the abdomen, and more flatus than usual. He had a motion, which relieved him; and no prolapsus of the bowel took place. Two gentle purgative pills.

8th.—Bowels moderately affected; scarcely any bowel came down, and it went up of itself; but there was a good deal of blood.

9th.—Much irritation; the bowels twice moved, with pain, uneasiness, and sickishness of stomach; he had eaten too full a dinner, and walked about; I recommended rest on the sofa, low diet, and a pill of five grains of Dover's powder at bed time.

10th.—Passed a good night; had a natural mo-

tion this morning without uneasiness or prolapsus; there was some blood, but as it was coagulated it had most likely flowed into the rectum after the previous motion. He was so well that I took my leave. He went to the country, and six days after I received a letter from him, saying,—“I arrived here the 12th, and have been every day since bleeding very much each time I go to stool, and pass very little through my bowels; I should say I lose on an average half a pint of blood daily, and nearly fainted twice, one day, in consequence. Otherwise, matters are well.” I wrote to him, recommending the daily use of a lavement of cold water with a teaspoonfull of powdered alum in it, expressing my belief that the bleeding came from the abraded surface caused by the severe application of the nitric acid, and that it would most likely cease in a day or two. I got a letter a few days after, saying that the bleeding had gradually ceased, and that he was quite well.

About two months after, he came to town; there was still a little prolapsus on exercising—an oblong excoriated firm portion. He was obliged to leave town the same day, so I could not apply the nitric acid a second time, which would probably have cured this. As it was, here was a case in which the acid had been so strongly applied as to produce serious bleeding, and yet the result was not completely effectual. And the result of two previous applications, three years before, had been temporary. In Dunbar, No. 5 Ward, the acid had been freely applied in another hospital with little beneficial effect.

A Roman Catholic clergyman, aged about 50, suffers from internal hæmorrhoids, which come down at stool, and occasionally bleed; but what most inconveniences him is, that there is some prolapsus when he walks.

I found the anus lax, and a small red granular pile, like an elongated raspberry, projecting out through the anus; besides this, he says that after having walked some time, one from higher up, and of a dark colour, like a grape, comes down too.

He has laboured under the complaint for fifteen years, and been cured twice, for a time, by the application of nitric acid. The acid had been applied by a most experienced and excellent surgeon, and yet the effect had only been temporary.

But where the prolapsus and bleeding hæmorrhoids are small, the nitric acid is a very safe and effectual remedy. There is a glass brush recommended for applying the acid. But you will find the common mode of application as good as any. A flat piece of wood, the size of a spatula, but a little narrower at the end, is to be wet with the strong acid and applied decidedly over the pile till its surface becomes greyish-white; a little oil is afterwards smeared over the part to prevent any free acid affecting the neighbouring parts. The chief things to be attended to are, not to take up too much acid with the stick lest it drop over other parts, and secondly, to apply it effectually.

Some inflammation, heat, and throbbing follow the application, and after the second day, there is often blood in the stools. This, in favorable cases, gradually disappears as the ulcer formed by the acid heals, and the inflammation having consolidated the walls of the rectum, the internal piles cease to come down.

Now let me remind you, that all these cauterizing agents have been proposed as safer modes of curing prolapsing and bleeding piles, than the two older operations of excision and the ligature. That they are safer than excision, there can be little doubt; indeed I wonder any one can be found bold enough to cut off internal piles, when we have the evidence of so many lives sacrificed by it. Dupuytreyn, an advocate for excision, was yet so aware of the danger of hæmorrhage, that he always left an assistant at the bed side, to apply the actual cautery to the bleeding vessel in case it came on—rather a terrible addition to any operation. Sir A. Cooper lost some patients by this operation, and abandoned it in consequence.

Sir P. Crampton mentioned to me, that early in life he had nearly lost a lady from hæmorrhage, after excision. As he could not get at the bleeding vessel to tie it, he had to keep his finger, and after he was tired, that of an assistant, on the vessel, up the anus, for several hours.

The following case conveys a good warning of the extreme danger of this operation:—I was asked to see, in all haste, a man who was bleeding after having been operated on for piles by excision. He had suffered for a long time from internal piles which came down at stool and bled freely. One of these piles had been cut off an hour before, and as the young man who was staying with him observed him to pass large quantities of blood in the *pot de chambre*, and to be getting very weak, he became alarmed, and the gentleman who had operated not being procurable, he had sent for me. I found the man blanched, and so weak that when I told him to get on the pot, and strain, he was barely able to do so. He passed about half a pint of nearly pure blood, partly clots and partly fluid; the bowel did not come down, therefore the vessel from which all this blood was coming was not visible. I introduced a gorget to enable me to find it, when it appeared high up above the internal sphincter, and was pouring out red blood per saltum, forcibly, running up into the bowel and out at the anus. This view was obtained with great difficulty, from his unsteadiness and being inclined to fall forwards from weakness, and the rapid flow of blood obscuring everything; indeed I never saw more furious bleeding from so small a source, and I am sure in another quarter of an hour, he would have been dead. I took up the vessel with a tenaculum and luckily the looseness of the parts allowed it to be dragged down, so that a ligature could be properly applied to it. The hæmorrhage was stopped, and with the exception of palpitation of the heart, he got well without any bad symptoms.

CASE OF INJURY OF THE KNEE-JOINT,

FOLLOWED BY ARTHRITIS, LOCAL PHLEBITIS,
AND SUDDEN PYEMIA.

By WILLIAM O'NEILL, M.B., Lincoln.

Last August I attended, with Mr. Taplin, a young man, 18 years of age, a teacher, who, whilst engaged with his class, dislocated his left patella, and ruptured a portion of the tibial end of the ligamentum patellæ, in a very simple manner, by kicking backwards under the form on which he was sitting. The dislocated patella was replaced, but the injury was followed by the usual symptoms of inflammation of the knee joint to a small extent, and subsequently inflammation of the femoral vein, the vein feeling full and hard, and the leg and thigh presenting all the appearance of phlegmasia dolens. Notwithstanding this formidable amount of disease the patient seemed to progress favourably until the sixth day, when he got a remarkable change: symptoms of great collapse suddenly set in, with nausea and vomiting; and when I saw him about noon on that day he was delirious and extremely prostrated, and lay on his back, with his legs extended—his face was pale and ghastly, and he and the bed-clothes about him were completely saturated with cold offensive perspirations. The tongue was coated, and he was passing beneath him copious fluid fœtid stools. There was also evidence of pulmonary inflammation in a short cough and rapid breathing, and loud tubular respiration, and ronchus and sibilus could be heard all over the lungs, with here and there a loose crepitating rattle. The heart's action was rapid and feeble, and the pulse at the wrist was so quick that it could not be counted, and so weak that it could hardly be felt. On examining the diseased limb we found it almost free from swelling, and the cord-like feel which the vein presented the day before was quite gone. It was evident that the contents of the vein had passed into the general circulation, and that the patient was being poisoned by the contaminated blood. In the evening he lay unconscious, with the jaws firmly clenched, and he died that night—death having taken place in less than twenty hours from the fatal change.

It is to be regretted that no *post mortem* examination could be obtained; but independently of this there can be no doubt whatever but the conclusions arrived at were borne out by the facts of the case. The rapid subsidence of the femoral vein and of the œdema of the extremity, taken in connexion with the sudden accession of the formidable symptoms narrated, pointed out in a plain unmistakable manner, that the contents of the vein had escaped into the circulation. Collapse and speedy death were results to be expected from the commingling of so large a quantity of purulent and other decomposing matters with the vital fluid.—Some of the symptoms, however, were of an ex-

ceedingly marked character, and worth bearing in mind, namely—the rapid flickering pulse, the profuse offensive sweats, and the fetid stools. The pulmonary inflammation was, doubtless, caused by the pus globules becoming arrested in the capillaries of the lungs.

This was unquestionably a rare termination of phlegmasia dolens, or obstructive phlebitis of the femoral vein, but on calling to mind that a plug of fibrine or coagulated blood, or slight adhesions, may alone isolate the contents of the vein from the rest of the circulation, the wonder is, that from rough manipulation or undue motion it does not occur more frequently. In this case the patient felt so free from constitutional suffering that it was with difficulty he could be induced to keep his bed. It is more than probable, then, that in some indiscreet movement he displaced the plug or broke down the adhesions, and thus let in the fatal flood which so quickly overwhelmed him.

But while obstructive phlebitis rarely proves fatal in this very sudden manner, pyæmia or diffuse inflammation is not to be considered an uncommon consequence of severe injuries to the knee-joint. From several which I could recount, I select one which occurred under Dr. Hutton's care in the Richmond Hospital Dublin, some years ago, and which is also remarkable for the peculiar nature of the accident. The particulars of it are detailed in the article, "Knee-joint, abnormal condition of the," in Todd's Cyclopædia. A young man, aged 25, was admitted into the Richmond Hospital, with an injury of the left knee joint, which occurred when wrestling. Being intoxicated at the time, his account of the manner in which the accident occurred could not be depended upon. The joint was much swollen, very tense, and painful; no fracture, and no other deformity than that occasioned by the general swelling of the joint, could be detected. The limb was maintained in the semi-flexed position on the outside. Inflammation and symptomatic fever ran very high, and the pain was excessive, especially on the least motion of the joint. On the eleventh day the pain and swelling had diminished. He could then raise the limb from the bed, but could not increase the amount of flexion. On the seventeenth day, symptoms of diffuse inflammation set in; these rapidly increased, and on the twenty-fourth day from the receipt of the injury he died. The knee-joint was found to contain eight ounces of purulent matter, in which flakes of lymph floated; the synovial membrane was soft, pulpy and vascular; the circumference of the cartilages covering the condyles of the tumor was in a slight degree absorbed. On flexing the joint the spine and central portion of the head of the tibia, with a considerable portion of its left articulating surface, were found torn up from the rest of the bone in one piece, and remained attached to the anterior crucial ligament.*

* The author, Mr. Adams, illustrates the case with a wood-cut. The preparation is preserved in the Richmond Hospital Museum.

STEEVENS' HOSPITAL.

CLINICAL REPORTS OF SURGICAL CASES.

By SAMUEL A. CUSACK, F.R.C.S., M.R.I.A.

Resident Surgeon, and Lecturer on Anatomy and Physiology.

Case of Dyspnœa from Bronchocœle relieved by division of the Cervical Fascia.

Michael Hayden, aged 17, was admitted into Steevens' Hospital on the 12th of March, 1857. He states that he has had a tumor in the neck about four years, which never gave him any inconvenience until twelve days ago, when, after a slight cold, it increased in size, and at the same time his respiration became obstructed. For the last six days his breathing has been very laborious, so much so as to keep him awake at night, and to make him discontinue his usual occupation. He is a butcher, and lives in Dublin; he is rather above the middle height, of a pale clear complexion; he has lived well, using a good deal of animal food. His sister, aged 27, has a similar enlargement in the neck, which has never caused her any inconvenience. On the morning of his admission into hospital, he had an attack of dyspnœa, during which his respiration was heard all over the ward, his face and neck were turgid from obstructed circulation, and his pulse became very quick and feeble. The attack lasted about half an hour, after which he had an interval of comparatively free respiration. The tumor extended from the larynx to the sternum, so as completely to prevent any operation on the *trachea*. He was put to bed and ordered a purgative draught, to be followed by an antimonial mixture, also a blister to the back of the neck, and to apply the stimulating embrocation* recommended by Sir B. Brodie as an application to sero-cystic tumours. At six in the evening he had another paroxysm of dyspnœa, during which the lungs were very feebly distended, and the number of respirations reduced to ten in the minute, the cerebral congestion was rather greater than before, and he began to talk incoherently. At 1, a.m., (March 13,) his friends sent the nurse for me, to say that he was dying. On going to the ward I found that he was comatose and unable to speak, and that his respirations were not more than five in the minute, the pulse being very slow and feeble. I had observed during the day that he was in the habit of obtaining some relief by pressing on the front of the tumor, so as to relax the investing fascia, and I had caused similar pressure to be made by an assistant (when he was no longer able to do it himself) with sensible relief to the patient. Guided by this circum-

* R. Spiritus Camphorati.
tenuioris ℞ giiiss.
Liq: Plumbi Diacetatis ℥i.
Fiat embrocatio.

stance I made a free perpendicular incision over the upper and front part of the tumor, so as either to afford him relief by the division of the fascia, or as a preliminary step towards passing down a large catheter through an opening in the crico-thyroid membrane; unfortunately during the time that this division of the integuments and fascia was being made, he ceased to breathe, and I was obliged to open the larynx for the purpose of introducing the catheter and establishing artificial respiration; in this part of the operation the only difficulty was to avoid the congested veins, as Dr. Kitching, who assisted me, was able to draw the upper portion of the gland quite away from the crico-thyroid space, while I made the opening, necessary for the introduction of the catheter. Immediately on the tube passing beyond the compressed portion of the trachea, the air could be heard entering by it, and by blowing into it a few times we succeeded in re-establishing respiration. After the tube had been in about two minutes, it suddenly became obstructed and had to be withdrawn, but he had now recovered sufficiently to be able to breathe without its assistance, and it appeared that the division of the fascia, assisted by some serous discharge from the gland, had relieved the pressure on the trachea, and he was soon able to speak. The wound was then closed, wet lint was applied to the portion of the gland which projected through the incision, and he soon fell asleep, having been without rest for several days before. During the next few days he suffered a good deal from bronchitis, but otherwise his respiration was very free. The gland, from which there was a constant discharge of serum, also became much smaller. In about seven days the opening into the larynx had closed, and peas were placed in the external wound to keep up the discharge. He states that his breathing is freer than it has been for some months; he remained in hospital six weeks, by which time the tumor had become so small as to be scarcely perceptible. He occasionally comes to the out-patients' room to show himself, but the tumor does not exhibit any disposition to enlarge again.

The operation of opening the trachea for the relief of dyspnoea is at all times difficult, but when, as in the present case, the thyroid gland is so enlarged that the trachea cannot be felt between it and the sternum, the difficulty amounts to an impossibility, the violent hæmorrhage which is always the result of an incision into this body being certain to render the operation inefficacious. There remains then the only alternative of opening the larynx above the seat of stricture, and passing down a flexible tube, or of freely dividing the cervical fascia so as to relax the fibres which seem to bind the gland to the trachea; in the present case I think the successful result may be attributed to this latter part of the operation, and that had it been done earlier, the necessity of opening the larynx might have been avoided. The operation

of dividing the fascia is recommended by some surgeons, but I have not been able to find any recorded cases in which it was successfully practised. About twelve months ago I saw a case in the Richmond Hospital, in which Mr. Fleming seemed disposed to try the flexible tube, but I believe it was decided in consultation to defer the operation, and the patient died. Mr. Fleming was kind enough to show me a larger-sized catheter, open at the end, which he had procured for the purpose; but from the experience of one case I should be inclined to prefer an ordinary extra-sized catheter, with several apertures cut in its sides, to one open at the end, as less likely to collect mucus in its passage down the trachea.

Meeting of the British Association.

The following were the communications made to the section of PHYSIOLOGICAL SCIENCE.

1. PROFESSOR ALISON—On the *a priori* principles of Biology.
2. DR. POZNANSKI—On the Connexion of Atmospheric Vicissitudes with Epidemic Disease.
3. DR. HAUGHTON—On the Oriental Bath.
4. DR. HAYDEN—On the Physiological Relations of Albumen.
5. M. L'ABBE F. MOIGNO—On an Apparatus for the local application of Chloroform.
6. DR. POZNANSKI—Notice of a new Sphygmometer.
7. DR. GAIRDNER—On the Mortality of certain Diseases.
8. DR. LANKESTER—On Alternation of Generations, and Parthenogenesis in Plants and Animals.
9. MR. LISTER—On the Minute Anatomy of the Lacteal System.
10. DR. LYONS, on the part of DR. HARDY—On an Apparatus for local application of Chloroform.
11. DR. MILLINGIN—On a new instrument for speedy and efficacious Vaccination.
12. DR. ROBERT M'DONNELL—On the Valvular Apparatus connected with the Vascular System of certain Abdominal Viscera.
13. DR. H. CARLISLE—Some Observations on the Functions of the External Ear.
14. DR. GAIRDNER—On the Action of the Auriculo-Ventricular Valves of the Heart.
15. DR. LYONS—On the Importance of a Uniform Standard of Micrometric Measurement.
16. MR. J. P. HENNESSY—On certain Pathological Characters of the Blood Corpuscles.
17. PROFESSOR F. C. FAYE—On the Mode of Action of some species of Animal Virus.

Our limited space will prevent us from inserting more than two or three in each number.

ON THE CONNECTION OF ATMOSPHERIC VICISSITUDES WITH EPIDEMIC DISEASE.

By DR. F. POZNANSKI, of Wilna, Russia.

The natural agents are salutary or noxious, according as they serve to confirm or annihilate the normal state of individuals. If modifications of natural agents, even those which are proper to the

seasons, produce generally morbid predispositions, it is impossible for it to be otherwise, when the natural agents offer extraordinary modifications. In fact, whenever such modifications occur, there is a general predisposition to a special sort of illness. This predisposition—an intermediate state between health and sickness—is always in proportion to the degree of modification in the natural agents; and as its basis is a modification of the organic functions, it secures from other maladies, which require for their existence opposite modifications. It is for this reason that during, and even before an epidemic, we seldom meet with maladies of another kind. The morbid predisposition must, in every illness, necessarily offer peculiar pathognomonic signs. Unfortunately those signs which offer most interest, are only determined in some chronic maladies—and even then in a manner more or less vague. We know, for instance, some signs of the phthisical, apoplectic, scrophulous, &c., constitution, but no one has hitherto thought of determining the signs of predisposition proper to every acute malady, and principally to epidemic diseases. It was during the cholera epidemic of 1848 that I conceived the idea of making researches of this sort. Starting from this principle that circulation and respiration diminish under the influence of condensed air, and that during the cholera epidemic there prevails an excess of atmospheric pressure with its consequences, I undertook, during the epidemic of 1848 and 1853, two series of observations, in order to determine the signs of imminence of cholera, or rather of epidemic predisposition. Of course, I directed my attention especially to the change of the pulse. These observations, carried out on both occasions on three hundred healthy persons at Wilna in a prison, and at St. Petersburg on a regiment of the imperial guards, were repeated daily for several successive months, and furnished the following results:—

1. During cholera epidemics, many individuals—although in the enjoyment of good health—are affected by a very striking diminution of the pulse, as low as 45, and even 42 pulsations in a minute. 2nd, This diminution is not accompanied generally by any morbid symptoms or indication. 3rd, In proportion to the diminution of the circulation, the blood becomes black and viscid, and, on the contrary, it remains normal during the epidemic, amongst those individuals who are not affected by the diminution in question. 4th, The cases of cholera, occur only with individuals previously affected with diminution of the circulation. 5th, The slackening of the pulse, which often precedes the choleraic symptoms for several weeks, may be considered as a pathognomonic sign of the imminence of cholera. 6th, The individuals who manifested signs of this imminence, have always avoided the attack of cholera, if they have accelerated the circulation of the blood by suitable treatment, regimen, &c. 7th, The slackening of the pulse

as well as predisposition and choleraic attacks, have in general been proportioned to the defect of energy in the circulation, and to the excess of atmospheric pressure. 8th, This slackening does not occur among the healthy when the epidemic has definitively ceased. In conformity to the facts generally known, I shall endeavour to group into the following sections the phenomena characterising the three periods which constitute the cholera:—

I. *Stage of Choleraic predisposition—Slackening of the Circulation.*

The principal phenomena of this period are: the pulse large, slow (as low as 40 pulsations to the minute), and disappearing rapidly;* the respiration slow, deep, mingled with sighs, and presenting but very slight irritability. Subsequently the animal heat less intense, paleness of the tongue and the other mucous membranes; numbness of the limbs, and an extraordinary disposition to the formation of ecchymosis; a defect of perspiration and of characteristic secretions (those from digestion, evacuation of urea, &c.); dulness of the senses, congestions to the head, strange apprehensions and appetites; borborygms, from serosities transuded into the alimentary canal, and the dispositions to diarrhoea which is the result. Phlebotomy furnishes a blood excessively venous, and which is moreover thick, viscid, devoid of fibrine and water, and abounding, on the other hand, in globules and albuminous parts, the consequence of which is, that the blood in the veins becomes coagulable, forms very rapidly, and the serous portions in it are defective. This intermediate stage between health and disease is generally accompanied by a peculiar indolence arising from the defective action of the nervous system, which, receiving a blood not sufficiently oxygenated, is necessarily altered in its functions. Moreover, the phenomena of this period, as they do not cause well-determined suffering, remain in general unperceived or neglected. If these phenomena are attentively observed, it will be recognised that they all have a common origin in the want of energy of the circulation.

II. *Collapse Stage—Primary Stagnation.*

The characteristic phenomena of this period form two thoroughly distinct groups: that of the stagnation of the blood in the peripheric, and that of congestions in the central organs. To the first category must be referred—absence of pulse, coldness of surface, cold breath, deep respiration, and a complete want of irritability in the respiratory organs, almost impossibility to cough and sneeze; lividity and rugosity of the skin; absence of per-

*All the variations of the pulse may be observed with remarkable precision by the assistance of the sphygmometer, an instrument which I have rendered as sensitive as practical, by the application of a hair, which prevents the capillary force.

spiration, urine, saliva, tears, bronchial and nasal mucus; an insatiable thirst; and a metallic voice caused by extreme dryness of the gullet and larynx, whose dimensions are changed by the dryness itself. Let us add, besides, to this category, the cramps which occur *per reflexum*, in consequence of the pressure on the nervous trunks produced by the stagnant blood. To the congestive group are referred—vertigo, pains in the head, heart, and stomach, oppressions of the chest, internal heat* want of sleep, the characteristic vomitings and purgings, which usually contain nothing more than the serosities of the blood. Phlebotomy furnishes no more blood in this stage, on account of sanguineous obstructions in the capillaries, which hinder the passage of the blood into the veins. I refrain from enumerating the well-known characters of the blood. The air expired in this stage presents less carbonic acid: nevertheless, the quantity increases as soon as what is called reaction comes on, a condition in which after the stagnation of the blood, the circulation and respiration are accelerated, and when the carbonic acid accumulated during the stagnation is eliminated from the organism.

III.—*Typhoid Stage produced by the consecutive Stagnation.*

The characteristic symptoms of this period are: the pulse small and frequent, a disagreeable heat, a colliquative sweat, and colliquative evacuations generally; a characteristic indifference, delirium, gnashing of the teeth, hiccup, drowsiness, &c., &c. In considering attentively, on the one hand, the characteristic symptoms of cholera, and on the other, the well-known signs presented by the organism when subjected to an excessive atmospherical pressure, we arrive at the conviction that these symptoms resemble each other to such a degree, that they may be regarded as completely identical.—Now, this identity, and the influence of the air in producing the epidemic, are amply confirmed by the following facts:—1st, The cholera is endemic in countries exposed to an excessive atmospherical pressure, as the East Indies, South Carolina, and other countries of the same nature of atmosphere, 2nd, Cholera epidemics have always been preceded and accompanied by an excess of atmospherical pressure, and their intensity has always been in proportion to this excess—as would appear by the published diagrams attesting such a relation observed at London, Paris, and St. Petersburg.—3rd, The Cholera rages principally on the banks of rivers, the sea shores, in low grounds, valleys, &c. The constant relation between the strength of the cholera epidemic and the lowness of the ground, has been proved by most careful observations made

* Although the temperature generally diminishes among those attacked with cholera, still the parts which are in direct connection with the congested organs, as the vertebral column and the occiput, do not present a lower temperature.

in England, and chiefly in London.* The same relation has been equally evident at Paris, and in France generally. The departments and arrondissements in which the air was most confined always suffered most. It is known that the central departments of France, as also Switzerland, have always been almost entirely free from epidemics. In Russia, the countries which border the Caspian sea, the level of which is six hundred feet below that of the Mediterranean, have always been the cradle of cholera epidemics. 4th, Cholera epidemics are always propagated in the direction of low grounds, banks of rivers, and other depressed localities. This is the origin of the popular opinion that this epidemic follows the watercourse. Besides, the great plain which extends from the Caspian Sea to Paris and London has been the path followed by the cholera in Europe. The constant proportion observed between the intensity of cholera epidemic, and the size of the harbours, confirms also the influence of the depression of the ground. For it is quite evident that the size and depth of the harbour depend chiefly on the lowness of the land, without which the water would have taken a totally different direction. 5th, The mountain heights have hitherto been free from this epidemic, a circumstance which has induced people to take refuge there generally against this scourge. 6th, The specific gravity of the air increases during the cholera epidemic, as has been proved by the observations made by William Prout, in London. "Now, the increase of the specific gravity of the air is always in the proportion of its density, which itself depends on the dryness and accumulation of the atmospheric column superimposed." 7th, The cholera epidemic is generally preceded and accompanied by an extraordinary calm, which proves the condensation of the atmosphere; on the contrary, the epidemic ceases ordinarily or diminishes after the storm necessarily connected with the rarefaction of the air. 8th, If there is any wind during the reign of the epidemic, it is generally dry; and the epidemic extends in a direction contrary to the wind, because the air is condensed in that direction. This observation, while compromising the miasmatic theory, forcibly corroborates the present one. 9th, The epidemic produces, in general, uneasiness and the deterioration of the blood; these effects can only be caused by an agent like the air universally diffused. 10th, Occupations which demand an exercise adapted to augment the active force, such as those of blacksmith, coppersmith, &c., protect to a certain extent against attacks of cholera, whilst the sedentary life predisposes to this disorder. This circumstance has led to the idea of copper preserving from cholera. 11th, The agents recognised as pernicious during the cholera, are precisely those which diminish the active force; whereas the influences which excite and increase it in a direction contrary

* See the diagram annexed to the report of the scientific committee concerning the cholera epidemic of 1854.

to the epidemic. The most striking and confirming opinion here exhibited, is the influence of the bleeding employed, in the first moments of stagnation, which is before the coagulation of the blood. It cures the cholera at the very moment of operation, which proves that the cholera depends on a mechanical impediment. 12th, According to observations of Dr. Caspar, cases of sudden death become, in general, more frequent as the barometric elevation increases.—The same circumstance has been noticed during the prevalence of cholera.

Lastly, I may refer here to my own observations above mentioned. It must be concluded from all those facts and observations, that cholera is no other than the result of an excess of atmospheric pressure. We can arrive, also, at the natural explanation of the phenomena attending this disease, from the vaguest premonitory signs of choleraic predisposition to the most prominent symptoms of the collapse and typhoid stages. In a similar manner are explained all the distinctive characters demonstrated by the autopsies. The intimate relation between atmospheric pressure and the cholera epidemic once firmly established, the mystery attending this disorder will disappear of itself. We shall then find perfectly natural and intelligible its endemic existence in some localities, and its entire absence from others,—the manner of its propagation and extension by the way of low localities, and in a direction opposed to the wind, at the same time sparing the elevated places,—the rapidity with which the cholera epidemic may be developed and may disappear,—the action of the different agents recognised as salutary or injurious in cholera,—the decided predisposition to the cholera exhibited by some individuals, and on the contrary, the almost absolute exemption enjoyed by other persons—and in all cases according to the prevalence of their active force. The primary cause of epidemic cholera consisting in an excess of atmospheric pressure, and the proximate cause being in a stagnation of the blood with its consequences, protection from this malady will be secured by recourse to those agents which sustain the energy of the circulation of the blood and respiration, as soon as there is observed the slackening of the pulse described as above. These agents must, in this respect, be considered as preservatives. In Great Britain, attempts have already been made to determine the individuals under imminence of cholera, and thus to moderate the ravages of the epidemic; but these efforts have been confined hitherto to the exclusive examination of the digestive organs, which, during the period of imminence, present only very equivocal signs. Now, the pathognomonic sign of the imminence of cholera is in the slowness of the pulse, and the public hygienist, while determining during the epidemic the individuals who are predisposed, and accelerating the circulation of the blood, might preserve entire populations from the ravages of the epidemic. I will finish with the

words of the celebrated English meteorologist, Glaisher:—"Were the meteorology of our town carefully ascertained, and collated with that at the metropolis, and both together with that of the country generally, in a short time we should be in a condition to elaborate a clear insight into the meteorological causes of cholera, influenza, and many phases of disease, which now burst upon us with the suddenness, and devastating power, and wrathfulness of a visitation."

ON THE ORIENTAL BATH. BY DR. HAUGHTON.

Some months ago, my attention being drawn to the Oriental Bath as a sanitary institution, I was induced to undertake a journey to the East, for the express purpose of determining what were its claims to consideration; and with this view I remained a month in Constantinople, collecting whatever information was to be had upon this subject, which is now commencing to attract so much attention in this country.

This bath is best known to the Western nations by the name of "The Turkish Bath," having been described under that title in most of the accounts which have appeared before the British public; but the truth is, that there is scarcely a nation in the East which does not possess a somewhat similar institution. There is a prevailing prejudice that the Eastern bath is only suited for tropical climates, and could not be adopted in these latitudes without danger; but we find that not only the ancient Greeks, but also the Romans, were acquainted with its virtues, and thought no expense too great to enable them to confer upon every citizen the luxury of cleanliness, the foundation of all sanitation.

It was the custom of the Romans to build baths in the different countries which they conquered; and accordingly the historian Justin informs us that they introduced them into Spain, after the second Punic war, where they continued in operation long after their suppression in other parts of Europe. From thence, according to Baccius, they passed into Germany and France, and even into the British Islands; and there is reason to believe, that were antiquarian research directed to this point, remains would be found in these countries, not upon the same scale as those of France and Germany, but sufficiently perfect to show the principle upon which they were constructed. It is of great importance that this principle should be well understood, and especially that we should observe the difference between it and the Russian vapour bath, which it most resembles. It is simply that of an oven, large enough to walk about in, and lighted from the top, that you may see what you are doing. The medium by which the bather is surrounded is hot air, containing a little moisture, that the tissues may not experience too great desiccation from its contact, and that the

softening of the loosened scales of epidermis, which is so essential, may be the sooner effected. In this bath water is not absorbed by the skin, as in the Russian vapour bath, or the steam baths of this country; but it is, on the contrary, given out by both the pulmonary and cutaneous surfaces in great abundance.

In the Russian bath, as described by Sir George Lefevre, the vapour is raised by pouring water over a stove, whilst the American Indian uses for the same purpose red hot stones, covered by the inner bark of oak, and upon which a small quantity of water is poured, to prevent too great desiccation; thus resembling the Oriental bath in being a sweating process, while it differs from it in the subsequent immersion in cold water, which is not practised by the Turks, although cold plunge baths, and even douches, may be found in Egypt, in connection with the more essential processes presently to be described. In the Western steam bath the vapour is obtained by boiling water externally, and is conducted by pipes into the box or chamber which is employed; but it operates on the system rather by virtue of its derivative and sedative action, than in consequence of any depurative or diaphoretic effect. All admit the advantage of keeping the *cutaneous* surface in such a condition as may be most favourable for elimination of the different substances which are got rid of by means of this extensive system of drainage. But it is also worthy of remark, that the pulmonary mucous membrane is capable of acting as an excreting surface, especially when the body is exposed to the influence of hot air, as in the Oriental bath. In this way a large quantity of alcohol and nicotine is excreted in those accustomed to the use of spirits and tobacco—the powerful odour communicated to the breath betraying the exit of the poison. In experiments made on the lower animals with phosphorus, this substance has also been exhaled with the expired air, the appearance presented in a darkened chamber being that of waves of light issuing from the nostrils. Now, while this pulmonary transpiration is very much increased in a hot dry atmosphere, it is almost completely checked when the air to be respired is heavily loaded with vapour, as is also the case with the functions of the skin. This is what constitutes the most striking difference between the bath of Eastern nations and the vapour baths of the West; and it is by no means an unimportant difference, inasmuch as the perspiration is intended by nature not merely as a means of ejecting superfluous moisture and effete tissue, but also as a natural safeguard to prevent the temperature of the body from being raised to an injurious extent. This safety-valve does not exist in the vapour-bath; and in using it our very lives may be said to be dependent upon a thermometer—for, evaporation being checked, the temperature of the body may be very quickly raised, and accidents are by no means rare from inexperience or carelessness in

the administration of the different forms of steam-baths. People also imagine that when in these baths they perspire very profusely, because on going out of them they are covered with large drops; but nine-tenths of these are simply the superfluous vapour which has condensed upon the body, and whose presence greatly impedes the natural exudation. In the Oriental bath, the small quantity of vapour which exists is only that which is produced by the water which is spilled on the hot floor during washing, and produces an agreeable soothing effect, instead of that suffocating sensation which one experiences in the Russian bath, in which, after having been half boiled, you are scrubbed with a hard brush, and flagellated with a bunch of twigs.

The first chamber which is entered serves as a dressing-room, where the clothes are deposited previous to entering the hot chambers, and where the bather remains to cool himself on leaving them. For this reason it was called the *frigidarium* by the Romans, although the temperature is about 25° centigrade, or something over the summer heat of our thermometers. The next room is about 10° hotter, and is called the *tepidarium*, where the bather reclines, and drinks some hot coffee, or smokes, until he is in the proper condition for entering the third chamber, which is only about 5° hotter. I paid particular attention to this point when in Constantinople, always bringing my thermometer into the bath, and in no instance did I find the heat above 40° centigrade (104° Fahrenheit). Were it considered necessary, however, an enormous heat could be endured in the Oriental bath. A French gentleman, who was nearly suffocated by the vapour of the baths of Nero, near Pozzuoli, in a temperature of 122° Fahrenheit, was able to bear a heat of 176° Fahrenheit, in dry air, without inconvenience. The floor of the bath being the hottest part, the stratum of air next it ascends continually, carrying with it the superfluous vapour, which condenses upon the roof, and creates an imperceptible current, which suffices to purify the atmosphere. In the third or hot chamber, corresponding to the *laconicum* of the Spartans, and the *calidarium* of the Romans, the bather is shampooed, a kind of kneading of the muscles; and the dead skin, with its adherent impurities, is removed by means of the goat's-hair glove; and the amount of extraneous matter which is thus collected from the most cleanly person, will excite some surprise in those only accustomed to the use of soap and water.

After the use of the glove the bather is next thoroughly washed with soap and hot water, performing part of the washing himself, as he is never naked during any part of the bath, the Turks especially being most scrupulous in this respect. When he gets up he puts on a pair of wooden pattens, to keep his feet off the hot floor, and returns to the second chamber, where he is lightly wiped, and again clad with warm towels—the

head being bound up to avoid taking cold. The bath is now finished, but it would be imprudent to go out, without remaining some time in the frigidarium to become cool. Here it is customary to lie down, well swathed in towels, and to drink some sherbet or coffee, and smoke. Nor does the bather require much persuasion to induce him to stop, as the sensations are so delicious, that it is only necessary to lie still to enjoy a mental calm and exquisite consciousness of health that few of us have ever experienced.

Here we have a pleasure which is not a vice—a luxury which does *not* tend to shorten life; and which only awaits a sufficient demand to give encouragement to capital, that it may become at once cheap and universally attainable. There is no drug in the *Materia Medica* at all comparable with it as a purifier of the blood; for even poisons are thus eliminated from the system; and it is well known that alcohol is frequently taken by the Turks in large quantities without producing inebriation. Besides which, they enjoy an immunity more or less complete from various diseases which are here prevalent, and which would be quite unaccountable were the influence of the bath to be denied. Gout is scarcely known; rheumatism is rare, and soon cured; workers in lead paints seldom are affected by colica pictonum; chronic skin diseases are very rare, and pulmonary consumption much less common than with us.

The Turks are indeed seldom ill, and are, on the whole, longer lived than the Western nations, if one may be allowed to judge from the number of old men to be seen in the streets, for unfortunately the government keeps no statistics. The physicians who have had the most experience in attending them are, moreover, of opinion that these happy results are really owing to the great attention which they bestow upon the functions of the skin; and Dr. Millinger (the Sultan's physician) informs me that the Turks themselves have always considered the public baths of Constantinople as supplying the place of a certain number of hospitals, which must otherwise be built. Of the former there are 300 open to the public, and every gentleman who can afford it has a private one in his own house; while there are only two or three public civil hospitals for a population of 900,000 souls, nor were these at all crowded when I was in Constantinople.

Facts like these may lead us to inquire whether the office which nature has intended for the skin is not really much more important than we are in the habit of considering it; and whether cutaneous respiration be really restricted to the lower animals.

It is an important practical question to the British public to know whether the Oriental bath is, in the first place, conducive to health, and, in the second, whether it is suitable to this climate. The first of these questions has been answered over and over again by travellers who have thus

recruited their wearied frames, and by the experience of one-fourth of the population of the world, who look upon the bath as not merely the greatest of luxuries, but as a necessity, without which life would be a burden to them.

We may perhaps be told that the bath has been discontinued in the West of Europe, because it was found unsuited for the climate and the genius of the people; but history furnishes other reasons to account for its disappearance—luxury and depravity did indeed enter the sanctuary, and in the endeavour to suppress them, the temple of cleanliness was destroyed. In the time of Constantine, a regular crusade was waged against them by the clergy, and the civil power being placed in their hands almost without restriction, they destroyed at one fell swoop the two greatest bulwarks by which the physical energy of the people had been preserved—bodily exercise capable of acting upon the entire muscular system, and a habit of cleansing the entire body. Thus fell the baths and gymnasia of Europe. The ancient bath is worthy of restoration, both as a hygienic and remedial agent. A beginning has already been made, and our native land has taken the initiative—the only building of this kind in the West of Europe being lately opened in the neighbourhood of the city of Cork, where it is used as a medical agent, with, I understand, considerable success. No doubt, further improvements will shortly be made, which will render it more serviceable as a remedy, both by additions and alterations in its manner of working. I myself, have suggested the introduction of a certain measured quantity of pure oxygen gas, which may readily be done by means of small tubes, whenever that element may appear to require renewal; and I am not without hopes that I may soon be enabled to bring before the profession, some further communication upon this interesting subject.

ON THE MORTALITY OF CERTAIN DISEASES

By W. T. GAIRDNER, M.D. Edin.;

Physician to the Royal Infirmary, Edinburgh, Lecturer on Practice of Medicine, &c. &c.

The notes I am about to submit to the section are not to be considered as involving positive and dogmatic statements, so much as tentative data for future investigation. They are, however, I think, not unimportant, as involving the proof of a most striking source of fallacy in the registration of causes of death, according to the methods ordinarily pursued. They show, in fact, that the estimation of the relative and absolute frequency of the different modes and causes of mortality, is an inquiry as yet in its infancy, and requiring modifications, not only of detail, but of principle, before it can be considered as based upon positive data. A few years since, with the assistance of a considerable number of my medical friends, I made a collection of about 270 cases of fatal diseases, in

proportions pretty equally derived from hospitals and from other sources, which series of cases might be regarded as exhibiting, not very unfairly, the ordinary mortality of Edinburgh, in a season free from remarkable epidemic disease. The returns received presented a rather small proportion of infantile mortality; in other respects, they represented all classes of the population, and nearly all ages, in something like the normal proportion. The facts bearing on the fatal event were usually stated in some detail, and not, as in most returns of mortality, by merely attaching an arbitrary name to the symptoms. Thus it soon became apparent that any attempt to assign each death to one cause only, must be arbitrary in the extreme, and must lead to grave inaccuracy as regards the ultimate statement of the frequency of certain causes. In fact, it has been clearly shown that men rarely die of one single disease: almost always there are complex conditions which cannot be, and ought not to be, rendered into a single form of expression. No doubt, one morbid form often predominates, and gives a character to the rest; but not less frequently it is entirely a matter of reasoning, and, therefore, of some degree of doubt, what is the primary and what the secondary disease. The consideration of these circumstances induced my associates and myself, in recording the results of our joint inquiries, to adopt a plan peculiar, so far as I know, to ourselves. Instead of registering one cause of death—one fatal disease—in each case, we determined to register as many as were clearly presented to us by the accounts furnished of the morbid history. Thus a result was obtained widely differing from that of the Registrar-General, and presenting a far greater approximation to the truth as regards some important particulars, than any return, however carefully compiled, founded on the ordinary system. I do not attempt to extend my statements, in the mean time, beyond the case of some very common forms of disease. First in importance, as in frequency, is tubercular disease, in the general sense, with its most frequent special form, *phthisis pulmonalis*. According to my returns the former is a cause of death to about one-fourth, the latter to rather more than one-fifth of the population included in these inquiries. According to the Registrar-General, the proportions in London were, in 1854, less than one-seventh of the whole mortality for tubercular disease, and less than one-tenth for *phthisis pulmonalis*. The great frequency of tubercular disease is thus assuredly underrated by the Registrar-General, though not to anything like the extent of some other morbid forms. Passing to diarrhoea, I find that this very important cause of death is enormously underrated in the Registrar-General's returns. Diarrhoea is, in fact, entitled to be registered as a source of mortality in little less than one-fourth of the population of Edinburgh. In other words, of one hundred who die, not less than from twenty to twenty-five owe their death in some degree to

diarrhoea. In the Registrar-General's returns it is only in cholera years that the cypher of diarrhoea reaches anything like this proportion; the proportion being, in ordinary years, from $\frac{1}{8}$ th to $\frac{1}{10}$ th of the general mortality. It is obvious that the residual cases, or those merged and lost sight of by the Registrar-General, are cases of complicated, but not on that account less real or less fatal diarrhoea; such cases are, in fact, an immense majority of the cases of this disease. Disease of the heart, in one form or other, I find to be cause of death to not much less than one-eighth of the population, as illustrated by my returns. The returns for London in 1840, show this cause of death as only affecting one-fiftieth of the population; since this period, however, the proportion has been gradually rising, evidently owing to the increased care of medical practitioners in reporting, and perhaps also of the Registrar-General in extracting from the reports, the cases to be placed under this head. I find no reason for adopting the popular theory that disease of the heart is in reality on the increase. I believe it is the art of diagnosis which has undergone change, not the frequency of cardiac disease. Pneumonia was fatal to $\frac{1}{11}$ th; pleurisy (often combined with pneumonia) to $\frac{1}{8}$ th; bronchitis to $\frac{1}{4}$ th of the population under my observation. These causes of death, also, are considerably understated in the Registrar's returns, and there is this additional anomaly, that while in the first of the reports of mortality in London the proportion of bronchitis was exceedingly small, it has now come to be for many years the preponderating form of chest disease, and counts its victims by hundreds, where it formerly counted them by tens. Is this a change in the character of disease, or in the character of diagnosis? I adopt the latter view, believing that there is no real evidence whatever of the enormous increase of bronchitis relatively to other forms of chest disease exhibited by the Registrar-General's returns. Next follows Bright's disease, including some of the allied diseases of the kidney, which may, with propriety, be included under the same heading. These morbid conditions I have found to be a source of mortality to about a tenth of the cases observed by myself and my associates. In the Registrar-General's reports for London, on the other hand, owing to the defective means of noting complications, Bright's disease finds its way into the returns in exceedingly small proportions; constituting in general terms not more than $\frac{1}{30}$ th of the gross mortality. A result so entirely inconsistent with medical experience as this, is sufficient of itself to show the perfectly enormous errors involved in the mode of proceeding by which one cause of death only is registered.

I may remark, in conclusion, that in thus pointing out a source of fallacy, and in suggesting the remedy, I by no means wish rashly to supplant the present system of registration for the whole country. The labour involved in a system free from the

defects pointed out, would be so prodigious as to stagger the most industrious and indomitable of statists; and the disadvantage of adopting any change in the present system, without preserving the means of comparison of results, is also such as to make it almost hopeless to propose any such measure. I would willingly, however, see limited experiments instituted upon the prevalence and mortality of the more important forms of disease. Such inquiries are well worthy the attention of the governors and medical officers of public institutions. The great point is to have them carefully executed, and this can only be done by some method which will prevent too great complexity of the investigation. The great object of most statists seems to be the accumulation of details, so as to procure very large numbers. This is, no doubt, necessary in some inquiries; but in vital statistics, a far more important object is the careful scrutiny and judicious appreciation of the conclusions fairly deducible from comparatively small numbers of cases, accurately and amply recorded. I would venture to propose, as a useful preliminary inquiry, the investigation of the most frequent only of the causes of death—excluding, in the mean time, those which are so rare as to require large masses of cases for their fitting display. The causes of death to which I have alluded, are among those of the first importance in frequency, and ought, therefore, to be worked out in detail before proceeding to others.

DR. MARSHALL HALL :

THE HISTORY OF HIS CASE, AND THE POST-MORTEM APPEARANCES.

If the pages devoted to the science of Medicine in this country, may with advantage be illustrated with interesting and important cases, on no occasion can a space be more usefully or more gracefully afforded than in the present instance. We have to record the particulars of the case of one of the most distinguished, most talented, and most industrious of her professors; for such a man in every sense, was the late Dr. Marshall Hall. To render the history of his case complete, it is necessary to go back some years previous to the appearance of the last severe and fatal symptoms; for some peculiar features connected with the earlier symptoms rendered the case somewhat different to those generally met with in practice, and made the sufferer himself, always patient, thoughtful, and suggestive, consider that it presented features worthy of notice; and also made him anxious that its investigation should be completed by a post-mortem examination.

His own account of an early inconvenience or difficulty in swallowing best explains the symptoms as they occurred:—"Some fifteen years ago," he wrote to a friend, "I undertook to deliver two long and distinct courses of Lectures on the Practice of Physic, during the same winter." His custom was to lecture from six to seven, and then from eight to nine, in the same evening. He felt inconvenience during this winter from hoarseness and cough for the first time, and began to perceive that minute portions of food were apt to remain in his pharynx, and that after meals he occasionally raised some small portions. This difficulty

of swallowing very gradually appears to have increased; and he was induced, some years ago, to consult Sir Benjamin Brodie and Dr. Chambers on account of the increasing symptoms of obstruction; but on Sir Benjamin passing a bougie, no evidence of obstruction by contraction of the oesophageal tube could be detected. Mr. Guthrie, whom Dr. Marshall Hall also consulted, told him that he was only suffering from what was called "clergyman's throat." But the dysphagia continued, and during deglutition much care was requisite in the act of swallowing, and food could not be hastily taken, and while in the act of swallowing much regurgitation could be heard by those sitting near him.

He considered this condition to be due to a defective reflex action which prevented the muscles of the pharynx from acting with sufficient power to propel all the food lodged in it; but the probability is, that there was some such dilatation of the pharynx at this early period as is sometimes met with, and which in a measure acts upon the aperture of the oesophagus mechanically, and thus interferes with the ready passage of food. Such were the symptoms which continued slowly increasing, but which never prevented a sufficient amount of food to be taken, both solid and fluid, to keep up proper nutrition, until about the end of 1855, when Dr. Marshall Hall first perceived that in the expectoration which he usually had in the morning there was occasionally a slight tinge of blood, and this especially after much speaking or exercise. The dysphagia also commenced from this time to be troublesome and serious.

Previous to this date Dr. Marshall Hall had retired from active practice in London, as he found his health was failing to a certain extent, and some spots of purpura appearing on his legs. He wisely determined at once to give up the anxieties of professional occupation though it entailed the sacrifice of a large professional income. He made a tour of the United States in 1854-55 and spent the following winter and spring in Italy. He returned to England much better in health, but not improved as far as the throat affection was concerned. After a short stay in town, he went to Hastings, and came to town again in October following. It was now that the symptoms of permanent stricture of the oesophagus were fully established. He had some time ceased to partake of solid food; milk, cream, and coffee were the fluids he chiefly preferred. With the evident obstruction there was constant copious expectoration of purulent mucus, somewhat offensive in character, and occasionally during each day tinged with blood. He was seen in consultation by Dr. Williams, Mr. Caesar Hawkins, Mr. J. R. Martin, and Mr. Pollock, all of whom were agreed as to the serious nature of the complaint. He was quite prepared for the expression of their most unfavourable opinion, and was even cheerful whilst under examination. In speaking to one of his medical friends, who was constantly with him whilst in town, he said, "I don't ask you what your positive opinion is as to my prospect of life, for no one can be certain of the result of a hidden malady; but I look upon my disease as a fatal one, and have long done so. I have no hope of recovery. I don't wish you to mention this to Mrs. Hall. I have no fear of death, and cannot be alarmed by the truth. My only wish to live is for the sake of others; but I am resigned to the alternative, if it be ordered that I should not live much longer." The calm, resigned, and almost cheerful manner in which he spoke at once showed the preparation and the courage of a man who knew his end was not far distant, though still, as ever, unselfish, considerate, and affectionate, for those dear and near to him.

Whilst in London he had a wish to have the nitrate of silver applied in solution to the supposed ulcerated part of the pharynx; but when advised not to employ it, he readily acquiesced in the opinion of those he had consulted. He had applied the solution to the throat when in the country, but had been apparently much distressed by it; and though he had expressed a wish for its application a second time, he evidently had no

great desire to persist in its use, from the distress it had occasioned.

After a short stay in London he removed to Brighton, He now placed himself under the care of Mr. Wildbore, whose constant care and attention to him he always spoke of with much gratitude, and to whose note-book we are indebted for the remaining particulars of his case.

After being settled in Brighton, he complained of, and suffered much from cold. It always distressed his throat, and rendered more difficult the efforts of swallowing. His room was obliged to be kept at a temperature of from 70° to 75°; his diet was entirely milk, cream, and coffee. In January this year he wrote to Mr. Pollock:—"I have been for two months at Brighton, and the complaint has made no progress, but in cold foggy weather my dysphagia is always worse. I am intensely susceptible to cold. I have been many days lately without blood in the expectoration; but last night it came on after going to bed, without any assignable cause. Everything I take is apt to leave particles in my pharynx, even a light-boiled egg. Hence the cause of the irritation and consequent ulceration there. If so slight a thing will irritate and produce exudation of blood, there is surely ulceration there, and this, in fact, has all along been my opinion." We shall hereafter see how true was the opinion he had formed of his own case.

There was at all times, to a greater or less degree, "a stinging, burning pain" behind the larynx; sometimes for a day or two it was absent. During February the symptoms were variable, the dysphagia increasing as the temperature became colder. Once or twice there was slight regurgitation of the fluid by the nose and mouth. Some considerable benefit was derived from sipping a solution of chlorate of potash in water several times a day, with marked temporary benefit to the swallowing, but the effect was not permanent.

In March he had a severe attack of gout, when much uric acid passed in the urine. This was relieved by small doses of potash sipped in water, and also used in an enema. The dysphagia slowly but gradually increasing, four pints of milk were now only taken in the course of the day, and it occupied nearly half an hour to get down half a pint.

On the 10th of March he walked out, after four months' confinement to the house. The sun was hot, but the wind very cold, and the following day he was confined to bed, suffering from bronchitis, and all his ordinary symptoms aggravated. During several hours no fluid could be swallowed, and on attempting to pass a tube for himself, an obstruction was met with, opposite, as he said, the first or second portion of the sternum. This attack left him very weak. He complained much of thirst, and said his feelings of hunger were dreadful. Still he was most patient, and even cheerful in conversation, under all his sufferings.

In a few days the attack of bronchitis passed off, and he now derived much comfort from supping iced milk and sucking small pieces of ice; but the exhaustion and emaciation were becoming considerable, and the quantity of fluid taken by the mouth was reduced to about two pints in the twenty-four hours. Mr. Wildbore therefore recommended him to allow the administration of nutritious enemata, of which the following was the mixture: five ounces of strong beef tea, one ounce of port wine, and three grains of quinine. This was given three times daily, and the whole quantity always retained. The quinine was added on account of his suffering from intermittent fever which came on every night. The enemata were evidently absorbed, for the bowels only acted once in three or four days under the influence of warm water enemata, with some salt dissolved in it, and his would be followed by a healthy motion.

On the 10th of April, for twenty-four hours, there was complete interruption to the passage of fluid through the throat; but on the following day he was again able to swallow milk and some wine-and-water

Towards the end of the month the difficulty of swallowing was so great, that if more than three teaspoonfuls were taken directly one after the other, the fourth would bring on cough, and the greater portion would be returned by nose and mouth, mixed with mucus, as if the fourth spoonful filled up the tube to the aperture of the glottis, and thus excited cough.

During the month of May he suffered much from hunger; but taking the enemata four and five times a day appeared to nourish him to the extent that he was able to bear the erect posture, which he could not a fortnight previously, owing to vertigo. The aguish attacks were also severe, and he took constantly about twenty grains of quinine in the enemata, which had the effect of relieving him, but produced deafness and singing in the ears.

In June the voice began to be affected; the expectoration, which had become white and frothy, was again purulent and offensive. The efforts to swallow were attended with much exhaustion, and the struggles to get fluid down were very great. The loss of voice at the end of June was unchanged; the "stinging, burning pain" greater, and debility increasing; the expectoration very copious. Notwithstanding his condition, about the middle of the month he ate a fair dinner of lamb and asparagus for three or four days consecutively, swallowing it all. Then came a cold wind and increased dysphagia.

In July, early in the month, he applied himself a four-grain solution of nitrate of silver to the pharynx five times. This increased the "stinging, burning pain" greatly for two hours after each application, but no beneficial result of any kind was obtained. Chills and profuse sweats attacked him every evening, and the aphonia continued. During July he gradually became weaker, and the quantity of fluid taken by the mouth was about a pint to a pint and a half of milk daily. It may be mentioned that nearly all the time he was at Brighton, up to the last few days of his life, he looked fresh and healthy, a circumstance somewhat remarkable.

By his own desire he went out, in the early part of August, in an open carriage, but all his symptoms were becoming worse: the breathing short and asthmatic, and the air-passages clogged with mucus. The rectum also became uncertain in its power of retention, and the enemata were sometimes returned. On August 11th, at twenty minutes past eight, he died, maintaining his consciousness to within a few minutes of his death.

His friend, Mr. Wildbore, wrote of him, but a few days before his death, "It is wonderful to me how he bears up against his disease. He is ever thoughtful of, and kind and considerate to all around him, and most grateful for the least kindness or attention shown him; always interested in professional questions, and ever active in mind upon those subjects which have chiefly occupied his attention. He is most patient, and perfectly resigned." All who knew and watched him during the progress of his disease, and witnessed the high courage and true resignation with which he submitted to his sufferings and to the prospect of death, will feel that Mr. Wildbore's estimation and record of him was only what was just to the character of the greatest of English physiologists.

The *post-mortem* examination of the body was made by Dr. Ransom, of Nottingham, thirty-eight hours after death, in the presence of Dr. Hutchinson, Dr. Robinson, Dr. T. Wright, Mr. Higginbottom, Mr. Eddison, Mr. Wildbore, and Mr. M. H. Higginbottom, and for the record of which we are indebted to Mr. Ransom.

The body was emaciated. No external marks of decomposition.

Thorax.—The lungs did not collapse on the cavities being opened. The right one was universally adherent by old adhesions; the substance of the lungs healthy; no pleuritic effusion.

The pericardium contained nearly two ounces of dirty red fluid. The heart was flabby (perhaps from cadaveric changes); it contained frothy blood in the

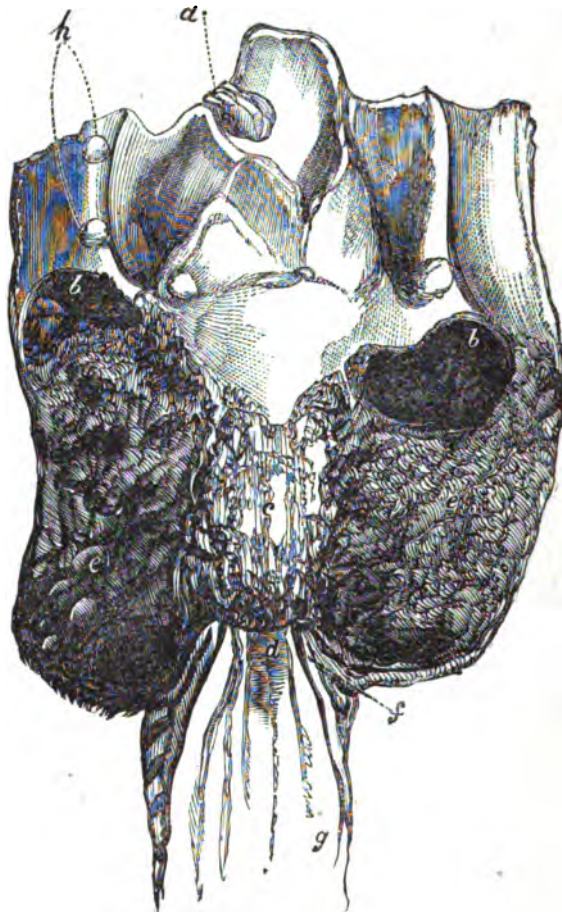
right ventricle and auricle. The valves were competent. There were some slight atheromatous deposits on the inner surface of the aorta, which was stained a deep red.

The bronchial glands were larger than usual, soft and black.

On making examination of the parts higher up in the throat, it became evident that some undue thickening and adhesions existed behind the larynx. The latter was therefore removed, with the pharynx, the œsophagus, and trachea. In doing this, the intimacy of the adhesions necessitated that the knife should be carried close to the bodies of the corresponding vertebræ; with every care, however, buttonholes were made in two or three places. On removal, it was seen that the walls of the pharynx were extremely thin, and that its cavity was dilated. Through the openings made by the knife there escaped a dirty-brown flaky fluid, of a creamy consistence. The adhesions were to the bodies of the sixth and seventh cervical and first and second dorsal vertebræ.

The parts removed, when examined, showed a stricture of the œsophagus, about the level of the eighth ring of the trachea, and a dilatation, with ulceration and vasculature of the œsophagus and pharynx above the stricture, to the extent of nearly three inches. The stricture was attended with but moderate thickening of the tube, and the aperture was not very small; but the membrane

was folded in, so as to present a conical eminence upwards, the apex of which was opposite the narrowest part of the stricture, which here was rather larger than a goose-quill. In this way the passage was almost valved, and food would have had the tendency to pass down by the sides of the eminence into the pouches and sacculi of the ulcerated portion. Indeed, the finger passed down from above, previous to opening the œsophagus, could not enter the passage, though a similar difficulty did not exist if the finger was passed from below the stricture. The upper border of the ulceration was, on each side, about level with the bases of the arytenoid cartilages, but did not extend so high in the middle. The dilatation was, throughout, irregularly ulcerated, soft, pulpy, ragged, of a dirty-grey or slate-colour, and with a few loosely-adhering flakes on its surface. Its base was not much thickened, though here and there it was somewhat so, and felt firmer in such parts. The walls of the pharynx and œsophagus were perforated in several places, leading to pouches or sinuses amongst the muscles of the neck, having very thin delicate walls of false membrane. Two of these pouches were very large, and ran upwards on the outer surface of the thyroid cartilage, one on each side, as high as its upper border, the right pouch being the largest. A narrow slip of mucous membrane remained at the back of the trachea, but this at the lower extremity was quite undermined.



STRICTURE OF ŒSOPHAGUS AND ULCERATION FROM DR. MARSHALL HALL. TAKEN FROM THE PREPARATION IN SPIRIT, AND PART FILLED UP FROM MEMORY.

- a, A little polypus.
- b, Opening of culs de sac
- c, Part of mucous membrane of œsophagus not destroyed.
- d, The stricture.

- e, The dilated and ulcerated part of œsophagus and pharynx.
- f, Section of stricture.
- g, Œsophagus, normal.
- h, Deposits on mucous membrane of pharynx

At the lower part of the dilatation the ulceration had nearly perforated the trachea through the posterior membranous wall, and had set free the right extremities of the fourth, fifth, and sixth cartilages. The pharyngeal mucous membrane above the ulceration appeared nearly natural, except for two or three little rounded elevations, as if there was a deposit in the mucous membrane, each less than half a pea in size. There was a small pendulous polypus attached to the thyro-epiglottic fold. The œsophagus below the stricture was healthy.

In the mucous membrane of the trachea directly corresponding to the deep ulceration that threatened to perforate it, was a small deposit or growth—semi-transparent, solid, and slightly elevated. There was a similar one higher up, inside the cricoid cartilage, but it was more opaque and white.

The patch on the tracheal mucous membrane was cut across, and from a section of it were obtained cells which possessed all the characters of cancer-cells. They were delicate, large, irregularly angular, with elongated processes; some were, however, rounded, had peculiar large nuclei and nucleoli; often several of these in one cell, and sometimes a cell-wall around one or more of the contained nuclei. Some few of the nuclei presented a delicate, regular radial striation, which Dr. Ransom observes he had not before seen. These cells were contained amongst the meshes of the elastic tissue. From the whiter patch on the inside of the cricoid cartilage, similar cells were obtained, but they were fattily degenerated, and therefore less characteristic. From the base of the ulcerated surface Dr. Ransom found in parts examined no satisfactory evidence of the nature of the pathological process which had preceded; but amongst a mass of granular and fattily degenerated elements, several bodies were always seen resembling retrograde cancer-cells.

The fluids from the surface of the ulcer consisted mainly of molecular detritus and fat, in drops and granules, with a great number of epithelium scales, mostly of the scaly variety; but a few were cylindrical and ciliated, probably separated from the upper parts of the pharynx. In the little elevations on the mucous membrane of the pharynx nothing was found but globular corpuscles and cells filled with fat granules of various sizes; and one beautiful hexagonal crystal-like cystin was observed.

A portion of the pharynx and œsophagus, examined by Mr. Caesar Hawkins, Mr. Pollok, and Mr. Holmes, curator of St. George's Hospital Museum, gave the following results:—

1. A portion of the disease was surrounding the great vessels in the neck, and apparently making pressure on the upper part of the pharynx. The interior appeared of a cellular character. Sections showed fibrous tissue, with numerous nuclear bodies, and much fat.

2. A small tubercle, beneath one of the rings of the trachea, contained an immense number of nucleated cells, resembling those of healthy epithelium, but of more curious form and size; also a good deal of fat.

3. A mass containing dark masses (of black pigment), otherwise exactly resembling the portion first mentioned.

NOTE.—Our readers are indebted to the Editor of the *Lancet* for an opportunity of examining the woodcut which adds so much to the value of this interesting case, which we have copied in full from its columns.

PRIZE OF THE MASSACHUSETTS MEDICAL SOCIETY.—A prize of 100 dollars will be accorded to the best essay on the question "To what affections of the lungs does bronchitis owe its origin." The competition is open to all countries, and the essays must be forwarded to the Secretary, Dr. Cotting, Roxburgh, Mass., post paid, by April 15, 1858.

COMPOSITION OF FRUIT.—Professor Wolff has examined several varieties of apples and pears. He gives as the average composition of seventeen kinds:—

	Apples.		Pears.	
Water.....	84.74		80.02	
Dry substance	15.26		19.98	
Insoluble substance	—	2.75	6.53	—
Substances dissolved	—			—
in the juice.....	—	12.25	13.43	—
Sugar	—	7.46	9.26	—
Pectin, albumen, & salts	—	4.23	3.01	—
Free (malic ?) acid	—	0.82	0.58	—
	100.00	100.00		

He found that pears differ more in composition from this average than apples, and that the essential difference between these fruits consists in the amount of sugar, which he found to be always two per cent. or one-fourth greater in pears than in apples.—*Pharmaceutical Journal*.

OPHTHALMIA IN PRUSSIA.—The affection of the eyes which has lately exhibited itself in so virulent a form amongst the troops in garrison here, is stated by medical men to be the Egyptian Ophthalmia; it manifests itself in a number of small white vesicles below the lower eyelid, which, if not promptly removed by a solution of lunar caustic, increase very rapidly, and soon extend in the form of a white crust or scab over the whole eye, and dry up its fluids. Although some entire regiments have hitherto escaped this infliction, others have had such considerable numbers of their men rendered unfit for duty that the men of the reserve have been obliged to be called out in order to keep up the regiments to even their peace complement. The exertions of the regimental surgeons have, for the present, succeeded in mastering the epidemic; and, if no new outbreak occurs, it may be looked on already as in a fair way of disappearance. The same seems to be the case with the sickness which has affected the horses of the cavalry in Potsdam. Very shortly after they were distributed throughout the surrounding villages it became apparent that they were recovering; so rapidly that they would soon be able to be brought back to their own stables and do duty. What the nature of this affection of the horses has been we have not been able to learn.

LOCUSTS.—Several specimens of that rare insect, the *Gryllus migratorius*, have been found lately in the neighbourhood of London; a very fine one was found feeding in Lincoln's Inn Fields, and immediately transferred to the Hunterian Museum; another flew into the shop of a picture dealer in the Strand, and was captured. Mr. Gaylard, M.R.C.S., of Plympton, Devon, has also secured a fine specimen for his entomological cabinet, one of the finest private collections in Devonshire. Two or three specimens have been also procured in Dublin and in the north of Ireland. Mr. Sweeny of Portobello, while passing over Carlisle bridge, Sept. 13, was attracted by a crowd pursuing a locust of much larger dimensions than one previously found in the College Park. Mr. S. captured it after much exertion, and presented it to Trinity College Museum.

REPORTS OF THE INSPECTORS OF COAL MINES.—The reports of the various inspectors of coal mines to the Secretary of State have been just published. It appears that last year there occurred the following number of fatal accidents—viz., in the northern districts, 135; in the North and East Lancashire districts, 84; in the West Lancashire and North Wales district, 103; in the Yorkshire, 52; in the Midland district (Derby, Notts, Leicester, and Warwick) 46; in the Stafford, Worcester and Salop district, 70; in the South Stafford and Worcestershire district, 156; and in the southern district, 65. In the western district of Scotland, 45 lives were lost during the year.

The *Russian Medical Gazette* mentions that the late war entailed upon Russia the loss of 392 medical men.

APPOINTMENTS.

The Board of Governors of the Richmond Lunatic Asylum, have recommended to his Excellency the Lord Lieutenant, Dr. JOSEPH LALOR, Resident Physician of the District Lunatic Asylum, Kilkenny, for the appointment of Resident Physician and Manager of the Richmond District Lunatic Asylum.

THE OPHTHALMIC CONGRESS.—First-Class Staff Surgeon Frederick Roberts has been selected by the Director-General of the Army Medical Department, and the Minister for War, to represent the medical officers of the British army at the congress of the Ophthalmic Society about to meet at Brussels.

THE ARMY.

WAR OFFICE, PALL-MALL, SEPT. 4.

6th Dragoon Guards—Assistant Surgeon Donald Sinclair Smith, from the 9th Light Dragoons, to be Assistant Surgeon, vice Moore, killed in action.

9th Light Dragoons—Assistant Surgeon Samuel Fuller, from the Staff, to be Assistant Surgeon, vice Smith, appointed to the 6th Dragoon Guards.

2nd Foot—Surgeon Luke Barron, M.D., from half-pay 1st Dragoons, to be Surgeon; Assistant Surgeon James Sinclair, M.D., from the Staff, to be Assistant Surgeon.

3rd Foot—Staff Surgeon of the Second Class Francis Oliver Barker, M.D., to be Surgeon; Henry M'Neice, late Acting Assistant Surgeon, to be Assistant Surgeon.

8th Foot—Assistant Surgeon Thomas Smith Hollingsworth, from the Staff, to be Assistant Surgeon, vice Domenichetti, promoted in the 75th Foot.

75th Foot—Assistant Surgeon Richard Domenichetti, M.D., from the 8th Foot, to be Surgeon, vice Coghlan, deceased.

HOSPITAL STAFF.

Staff Surgeon of the Second Class John Riggs Miller Lewis, M.D., from half pay, to be Staff Surgeon of the Second Class, vice Barker, appointed to the 3rd Foot.

Assistant Surgeon James Davys to be Staff Surgeon of the Second Class.

To be Assistant Surgeons—James Greig Leask, M.B., late Acting Assistant Surgeon, vice Carte, appointed to the 4th Light Dragoons; Spencer Boyd Gibb, M.D., late Acting Assistant Surgeon, vice Smith, appointed to the 19th Foot; Robert Arthur Elliott, Gent, vice Johnson, appointed to the 17th Light Dragoons; William Collis, late Acting Assistant Surgeon, vice Shortt, appointed to the 20th Foot; Thomas Rawlings Mould, Gent., vice Munday, appointed to the 20th Foot; John Wallace, Gent., vice Paliologus, appointed to the 34th Foot; Richard Armstrong Hyde, Gent., vice Dumbreck, appointed to the 97th Foot; Edward Joseph Crane, Gent., vice Bradshaw, appointed to the Rifle Brigade.

WAR OFFICE, PALL-MALL, SEPTEMBER 11.

Royal Artillery—Staff Surgeon of the Second Class Thomas Park to be Surgeon; Assistant Surgeon Joseph Read, from the Staff, to be Assistant Surgeon, vice Bowen, resigned; Assistant Surgeon Robert Lewer, from the Staff, to be Assistant Surgeon, vice Daniell, resigned.

94th Foot—Assistant Surgeon Edmund M'Grath, from the Staff, to be Assistant Surgeon, vice Martin, promoted on the Staff.

HOSPITAL STAFF.

Assistant Surgeon Henry Clinton Martin, from the 94th Foot, to be Staff Surgeon of the Second Class, vice Park, appointed to the Royal Artillery.

The Commission of Assistant Surgeon William Henry Leslie, M.D., to bear date 7th May, 1855, instead of 1st August, 1857, as stated in the "Gazette" of the 28th ultimo.

THE NAVY.

Acting Assistant Surgeons—A. J. Fitzgerald to the Cyclops; Richard Purbes to the Imaum.

NATIONAL ASSOCIATION FOR THE PROMOTION OF SOCIAL SCIENCE.—A new Society has been formed, entitled the "National Association for the Promotion of Social Science;" and the first meeting is announced to take place on the 12th October, at Birmingham, under the presidency of Lord Brougham. The object of this Association, in the language of the prospectus, is, "to aid the development of the social sciences, and to guide the public mind to the best practical means of promoting the amendment of the law, the advancement of education, the prevention and repression of crime, the reformation of criminals, the establishment of due sanitary regulations, and the recognition of sound principles in all questions of social economy." The proposed mode of action is, to bring together, once a year, the different societies and individuals who are interested in furthering any of these objects. Among the general committee we observe the names of several distinguished members of the medical profession, and among others, those of Sir James Clark, Sir John Forbes, Dr. Conolly, Dr. Babington, Dr. W. Farr, Sir Charles Hastings, Dr. Southwood Smith, and Mr. Simon; and among the laity who are friends of the profession we find the names of the Right Hon. Mr. Cowper, the Right Hon. Mr. Napier, Mr. Headlam, and Mr. Hawes. In the Department of Public Health Lord Stanley is President; and the committee comprises the names of some of the most active promoters, both lay and medical, of the objects of sanitary science.

DEATHS.

September 7, at Brighton, aged 75, SIR CHARLES MANSFIELD CLARKE, M.D.

We have to announce the sudden death of Mr. EDWARD LONSDALE, the eminent surgeon, who died September 11, from rupture of a blood-vessel, at his house in Motague-street. This gentleman was a son of the distinguished artist whose paintings are still admired by the connoisseurs of the present day. Mr. Edward Lonsdale was greatly respected by the medical profession, and had contributed largely to the literature of orthopaedic surgery, and thrown much light on the general subject by many papers and lectures scattered through professional periodicals. His sudden death will be lamented by a large circle of friends and acquaintances, by whom he was beloved and esteemed for manliness of character, urbanity of manners, and attractive social qualities. By his death vacancies occur in the surgery to the Orthopaedic Hospital, and to the Artists' Benevolent Fund.

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CLINICAL REMARKS ON THE TREATMENT OF INTERNAL HEMORRHOIDS.

By JOHN HAMILTON,

Surgeon to the Richmond Hospital.

THIRD PART.

There is another operation—that proposed by Mr. Hey—both for prolapsing piles, and also for genuine prolapsus, or a descent of the entire walls of the rectum through the anus—a true *intus-susceptio*. This operation consists in the excision of the loose flaps of integument on each side of the anus, going a little into the anus. It is followed by inflammation, extending into the cellular tissue external to the rectum, binding the latter to the adjacent parts; and also by contraction of the *mus*, which cures the disease. It is a most useful operation when the anus is very relaxed, and in some cases I have found it very successful; but the effects of the operation are occasionally severe.

A clergyman, æt. 56, generally healthy, and very temperate in eating and drinking, has suffered for nearly ten years from prolapsus ani. Every time at stool a portion of the bowel comes down, and is readily reducible. There is no blood; but the most material inconvenience is, that if he walks far it stands a long time—which in public speaking is often obliged to do—a portion of the bowel actually comes down, with some moisture, and great uneasiness. This has latterly become so troublesome that, to obviate it, he has had in the last a high wooden seat, or horse, on which he sits astride, and, by the pressure on the anus, kept a descent of the bowel in check. On examination, the anus looks very relaxed, with some loose vaginal folds. When the sides of the anus were separated, a small loose purple portion of bowel came readily down; and after he had strained at stool, a circular fold of deep-red bowel prolapsed round; not internal piles, but the bowel itself. In consultation with Sir P. Crampton, the operation determined on was that of Hey, modified

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by Dupuytren, removing the loose folds at the side of the anus, in the direction of the rugæ—that is, at right angles to the anus.

June 30th (Wednesday), 1852.—I cut off two folds at each side of the anus, and in doing so was careful to cut only the skin, and to avoid, if possible, the large veins, the bulbous ends of which were obvious through the integument. The bleeding was trifling.

Thursday (second day).—He passed a restless night, from uneasiness behind; skin hot, but the pulse is quiet. The parts about the anus were a good deal swollen, œdematous, very tender, and rather hot. I applied a bread and water poultice. Towards the latter part of the day he was very uneasy, from a feeling of strangulation of the bowel at the anus; his countenance anxious. The swelling had increased considerably, forming two large rolls at each side, tense and tender; they were formed by the rapid and excessive effusion of lymph into the loose cellular tissue of the part; but what showed that the inflammation extended higher up was, the protrusion from the centre of the anus, between these two folds, of a large mass of red swollen rectum. It appeared to me that, in consequence of the inflammation of the cuts having proved excessive, and having extended to the rectum itself, the latter had become swollen, and the effort at passing water had brought it down.

With great gentleness I reduced the greater part of this; and though, from the tenderness of the prolapsed and inflamed rectum, the operation was painful, still it gave much ease. My finger felt the inside of the bowel to be very hot, and a large artery beating strongly. Spirit lotion was applied. At bed-time he was better, though a red portion still protruded from the anus. He was restless, and experienced a desire to pass a motion every now and then. Ten grains of Dover's powder were given at bed time.

Friday (third day).—Better. The Dover's powder, though it did not cause sleep, removed the tenesmus. The protrusion is less, and paler—of a more livid colour, smeared with slimy mucus; feels the sensation of a lump there, but no pain.

He had temporary difficulty in passing water. Some tepid water injected into the rectum passed off unchanged, but he was more comfortable afterwards. Pulse quiet; no abdominal tenderness; a gentle laxative.

Saturday (fourth day).—Passed a tolerable night; the swelling pretty much the same. In performing the operation, when I removed the folds I could perceive, at the left side particularly, now the principal seat of the swelling, that the part immediately beneath the lax integument was composed of veins full of dark blood. The veins became inflamed (the adhesive phlebitis), and can now be felt quite hard, the blood in them coagulated.

Sunday (fifth day).—With the exception of a feeling of faintness in the middle of the day, there was a steady improvement. He passed a small motion yesterday, and to-day a very good figured motion, with much relief. The swelling is lessening.

Monday (sixth day).—He took some laxative electuary last night, and had two motions, the last followed by a good deal of pain, which I found caused by a prolapsus, which forcibly distended the anus, and thus caused the pain. It was easily reduced, and I could then distinctly feel that the lower end of the rectum, at the left side, continuously from the swollen external ridge, was swollen and hard, in knots, from the inflammation of the veins, and the consolidation of the blood in them.

After this the external swelling at the left side, from protrusion, gradually subsided, but not till a superficial layer had sloughed off. He suffered for a few days from diarrhoea, in consequence of the inflammation of the lower part of the rectum extending upwards. He left Dublin on the fifteenth day after the operation. Eight months after I received a letter from him, saying—"I am thankful to say I have a good report to give of the effects of the operation. At every evacuation I have a slight prolapsus of the lower bowel, but it is very slight, and reducible by a touch. At all other times, whether riding, or walking, or speaking, I am free from inconvenience. I have more than once spoken with considerable physical energy for nearly two hours, without the slightest recurrence of the painful annoyance I had experienced for some years prior to the operation. Your favourable anticipations are all realized, with the slight exception that you seemed to think it possible, rather than probable, that the bowel might acquire a habit of adhesion, so as not to come down at all."

April, 1857.—He consulted me to-day about some other matter; he has no prolapsus, and the anus looks quite natural. During five years, therefore, the cure has remained permanent.

Mr. B. has, when straining at stool, a small red lump of bowel coming down at the right side; it is the size of the point of the forefinger, with a rather

broad and long base, abraded on the surface, which is granular, and bleeds sometimes rather smartly, though never to an amount sufficient to weaken him; but the protrusion not only takes place at stool, but occasionally when he takes exercise; it is then rubbed and irritated, and there is some discharge. The anus is relaxed, and surrounded by three loose prominent folds of integument—one rather purplish, at the same side as the prolapsed pile.

He has suffered from the disease several years, and it has latterly been more troublesome. In consultation with Sir P. Crampton, it was agreed to endeavour to cure the prolapsus by cutting off the three pendulous folds of skin close to the anus and to the muco-cutaneous membrane of the lower end of the rectum. This was accordingly done with a scissors; lint, wet with tepid water, kept afterwards applied to the part.

Second day.—In the morning he was very well, but in the evening he suffered such pain that I was sent for. I found the part a good deal inflamed; a lump of a livid colour on the right side of the anus, in the situation of the usual protrusion. Warm stuping relieved him.

Third day.—He slept tolerably well, and is free from fever, but suffers from darts of pain in the anus, and the part at the right side looks swollen and inflamed. Some electuary he had taken operated in the evening with much pain.

Fourth day.—There was a second motion at eleven o'clock last night, an hour after which pain began; and in spite of ten grains of Dover's powder, he passed a disturbed night.

Fifth day.—I was called up to see him at half-past five o'clock. The internal pile at the right side, next to the fold I had cut off, was very much inflamed; it bulged out through the anus the size of a damson, and, from its deep purple colour, not unlike one; it was hard, from the coagulation of the blood in it, and exquisitely tender. There was a fringe of cedematous swelling round the anus. Though the internal pile had the appearance of strangulation through the anus, yet it could not be reduced, and any attempt at doing so was accompanied by much pain. An injection of tepid water, which brought away a motion, and afterwards a warm bread and water poultice, gave great ease.

Sixth day.—Free from uneasiness to-day, though he passed a figured motion from the bowels. During the whole of the local pain and inflammation, there was no constitutional disturbance, the pulse remaining quite quiet. He suffered comparatively little after this, though the protruded pile became of a greenish-brown colour, and finally sloughed off. On the fourteenth day he was well; a solid motion passed without pain or prolapsus; the anus looked tight, with three small granulating spots round it. It is now four years since the operation, and he has never had the slightest return.

In both these cases the violent local symptoms were, no doubt, caused by adhesive phlebitis of the

hæmorrhoidal veins; and it is very probable that the complete and effectual cure in each arose from the inflammation after the operation, which I believe, except for this, in cases of any extent, would fail in its object. It appears, therefore, questionable how far this operation of removing the pendulous folds quite close to the margin of the anus, when effectual, is less dangerous than that of tying the pile; for the local inflammation excited in either case may, in certain constitutions, run into purulent phlebitis, diffuse inflammation of the loose cellular tissue external to the bowel, or gangrene of a portion of the rectum itself—effects, happily, of extreme rarity, but which we know to have happened in the best hands; the constitution, not the operator or the operation, being at fault. Now, if this operation of Mr. Hey is not followed by some inflammation, I believe it to be very often an ineffectual one.

The last operation to which I shall direct your attention is that of tying, or applying a tight ligature round the base of the hæmorrhoid, so as to strangle it, and cause its death and removal. But not only is the pile killed and cut away by the ligature, but its effects extend further: the inflammation attending the separation of the pile extends beyond it, and causes adhesion between the loosened walls of the rectum and adjacent parts, thus preventing future prolapsus. It is the most effectual operation of all, and has been recommended as such by some of the best and most recent writers on the subject—Syme, Curling, and Quain. I believe it to be usually a safe operation, but not always; and it is in consequence of the occasional occurrence of purulent phlebitis and diffused inflammation, that the use of the nitric acid and other caustic has been proposed.

If you select your cases with judgment, you will avoid such sad casualties. In people of gross habit of body, of indolent pursuits, full feeders, and free drinkers, with liver or other organic disease, or in those who have passed many years in India, the smallest operation is serious. Sir B. Brodie lays much stress on a most important point of preliminary investigation, viz., the state of the kidneys. Disease of these organs is often most obscure, and only decidedly to be ascertained by the conditions of the urine. He cautions against operating where the presence of albumen is ascertained.

The operation of tying a pile is very simple, and is thus performed:—The patient strains over some hot water in the night-chair, till the piles prolapse; he then leans over the side of a table, and straining a little, they appear fully in view. One of them is seized with a forceps, and pulled down, and a strong silk ligature is put round the base, and tied tightly. The pile selected should be that which bleeds, and one or two of the most prominent of the others should also be tied. If they are very near the margin of the anus, great care should be observed not to include any of the common skin in the ligature, for it gives great pain; whereas otherwise little

pain is felt. A spring forceps with sharp points is often used to seize them; and in applying the ligature, when the hæmorrhoid is large, some surgeons pass through the base a curved needle armed with a double ligature, and tie on each side. I would not recommend either of these proceedings, or any mode of operation in which the veins are pierced. Though the claws of the spring forceps are so short that the thick coats of the vein are not transfixed, it would be better to use a forceps which holds firmly without any points. Professor Simpson, of Edinburgh, showed me a pair invented by Louis, which would answer well, as they take a firm hold without inflicting the smallest wound in the coats of the veins. With this object in view, I have been in the habit of using the ordinary palpebral forceps, and found them do very well.

When the prolapsing mass of piles is large, and the anus lax, and surrounded by loose folds of integument, it conduces to the success of the operation, after the piles have been tied, to cut off some of the loose cutaneous folds at the margin of the anus. This double operation is most effectual, and the cure generally persistent. It is the operation you have seen me perform in some of the aggravated cases of bleeding and prolapsing piles which we have had in the hospital. The detail of one or two cases will suffice to show the mode of operation, and its results.

*Prolapsing Piles, with much loss of blood at stool.
—Ligature of the Piles, and removal of the loose skin at the margin of the anus.—Cure.*

Henry Kelly, aged 56, a letter-carrier, No. 9 Ward, February 1856, complains of bleeding piles and prolapsus. On examination, the anus is found relaxed, surrounded by loose pendulous flaps of skin, and when he strains, a number of purple tumors come into view, which ooze blood freely. At stool he suffers from painful and involuntary tenesmus, as well as from the piles coming down and bleeding. Occasionally the discharge of blood is very copious; he loses, habitually, half an ounce as well as he can ascertain, at each motion; a good deal of slimy mucus, which smarts him, comes away too. He experiences great difficulty in returning the bowel, two hours being frequently occupied in the attempt. It also comes down on the least exertion, or walking, obliging him to wear a compress and bandage. The parts are kept wet by a constant oozing from the anus. The disease is of twenty years' standing, for the last eighteen years of which he has been more or less subject to bleeding. Till lately he has been tolerably healthy; but he has latterly become weak on his limbs, suffers from palpitation on exertion, and some difficulty of breathing, so that he can scarcely discharge the duties of his calling. The complexion is sallow and anemic, but there is no evidence of any organic disease, either of the liver, lungs, or heart.

For the last eight years he has had right inguinal hernia, brought on, he thinks, by the straining at stool. Bowels costive, tongue clean, pulse eighty. Appetite good. He has never been the subject of any operative treatment. On the 26th he was ordered an oil draught, and on the 27th February, the operation was performed.

The patient having strained over hot water, and the bowel being fairly protruded, Mr. Hamilton tied four of the hæmorrhoids; one on the right side, firm and dark purple, two on the left, and one behind. The parts were then reduced and four portions of the folds of skin at the side of the relaxed anus were cut off with a scissors. A good deal of smarting pain followed, with some difficulty in passing water.

Second day (28th).—Little pain about the anus; no difficulty in micturition; slept well, pulse quiet, tongue clean, no motion from the bowels.

Third day (29th).—Anus rather sorer; a pint of tepid water thrown up the rectum, produced no motion.

Fourth day (March 1st).—An oil draught produced a slight motion.

Sixth day (3rd).—An enema acted slightly, there was some prolapsus and a little bleeding.

Eighth day (5th).—At 2 o'clock this morning he had a copious motion, and the bowel came down to a great extent, which he could not return. He allowed it to remain down till the hour of visit at ten o'clock. It was then a good deal inflamed, hard, tender, and discharging abundantly a thin matter. There was a good deal of pain and irritation, skin hot but the pulse quiet.

The prolapsus was oiled and reduced, and an opiate enema administered, with ten grains of Dover's powder. A compress wet with spirit lotion applied to the anus.

Ninth day (6th).—All irritation subsided.

Tenth day (7th). A good motion this morning and no prolapsus, and very little pain.

A few days after, he left the hospital quite well, and has never had a relapse since. His general health better than it has been for years.

In this case the operation caused inflammation of the bowel and adjacent parts, most intense on the eighth day, rather later than usual. The swelling of the rectum from this inflammation was so great, that the prolapsus was larger than before the operation. It is important to bear in mind that this constantly happens, and to make the patient aware of it; because otherwise when he passes a motion some days after the operation, followed by a large prolapsus, he would fear that the operation had failed.

In the two preceding cases the anus was so relaxed that it was necessary to perform the double operation. In another man of the name of Hiram Murray, in No. 5 Ward, who came in on account of Kelly's cure, it was only necessary to tie the piles, because the anus appeared tight after the prolapsus was returned, and free from the pendulous folds of

skin. There were five or six large granular tumors, the size of gooseberries, of a dull red colour and which bled on the least touch, and very freely when they prolapsed at stool. Four of them were tied, and on the eighth day he left hospital quite well, neither prolapsus nor bleeding when he passed a motion.

Bleeding and Prolapsing Hæmorrhoids.—Operation.—Cure. Case by Mr. F. CRUISE.

J. D. aged 34, shoemaker, admitted to No. 9 Ward, Richmond Surgical Hospital, October 29, 1855, under the care of Mr. Hamilton.

December 3rd.—He has been for the last six weeks under treatment for syphilitic pains, especially severe in the clavicles, sternum, and acromion processes of the scapulæ. He has suffered from bleeding piles for the last eight years. On examination the anus is found relaxed, surrounded by a circlet of pendulous flaps, lined on the inner aspect by mucous membrane, externally by plain integument. The sphincter is dilated, and does not close the anus perfectly. On straining at stool sufficient eversion of the bowel takes place to bring into view three internal piles; one large, red and granular, not unlike a raspberry, situated on the right side; more posteriorly, and on the left side, there is another, considerably smaller and not so red. Quite posteriorly there is a small purple excrescence, evidently formed by a plexus of veins. He attributes the disease to habitual costiveness and the practice of using powerful purgative medicines. His habits have not been temperate. From the commencement the piles have been subject to bleeding and to exacerbations; in the intervals he is comparatively at ease, excepting towards the approach of an attack, the piles then become inflamed, excessively painful, and he becomes unable to return them when they come down at stool. The sphincter is affected with spasm and constricts them tightly, producing exquisite torture and distress. On one of these occasions, about two years ago, suppuration of the pile occurred. Any considerable discharge of blood is followed by complete temporary relief. The attacks are irregular in their accessions, but worse and more frequent in spring. Prolonged constipation, straining at stool, or any excess in drink, invariably bring them on. Ordered a dose of castor oil.

December 4th.—The oil draught has acted well. This morning Mr. Hamilton performed the following operation:—The patient having strained so as to bring down the bowel, was placed leaning over a table, the nates being then separated, each of the piles was successively drawn out by means of a forceps, and then included in a strong silk ligature which was drawn as tight as possible; they appeared soft and very slightly sensitive. Now the patient was placed lying on the left side, and the bowel reduced; then a few of the loose folds at the verge of the anus were removed with a curved

scissors, carefully avoiding any veins which could be seen; a couple of folds were removed from each side. No hæmorrhage to signify followed this operation; a compress of lint dipped in cold water was applied, and secured by means of a T bandage.

December 5th.—Suffered intense pain during the four hours succeeding the operation; towards evening he got an anodyne which procured him sound rest last night; this morning he had a stool, without much pain and with very trifling protrusion of the intestine; it was easily returned; the anus is red and swollen, and tender; a linseed poultice was applied.

December 6th.—Tumefaction and tenderness around anus worse; passed a motion to-day with considerable pain and tenesmus.

December 8th.—Inflammation about anus on the decline; some pain at stool; no prolapsus, or bleeding.

December 10th.—Pain at stool continues, but is much diminished in severity. The anus is no longer swollen or tender, appears less relaxed than before the operation. The raw surfaces left by removal of flaps are cicatrizing. Some days after the last report, he felt sufficiently well to leave the hospital.

He returned six weeks after and was perfectly well, neither bleeding nor prolapsus at stool.

LECTURES ON DISEASES OF THE STOMACH.

By DR. LEES,

Physician to the Meath Hospital, Lecturer on Practice of Medicine.

DYSPEPSIA.

HEADACHE; CONDITION OF URINE; SYMPATHETIC AFFECTIONS.

Dyspeptic patients often suffer much from violent pain in the head, commonly termed sick or bilious headache, which is well described by Dr. Fothergill, in the 6th volume of the "Medical Observations and Inquiries." It generally comes on early in the morning, on awaking or on getting up, when they feel giddy; the pain seldom affects the whole head, but most frequently the forehead, or it may be confined to a spot over one or both eyes, and sometimes the back of the head is the part affected. There is often nausea and vomiting of very acid and bilious fluids, when the pain subsides, leaving a sense of soreness of the head, and sleepiness, after which they awake quite recovered but very weak. Dr. Child is of opinion that this condition depends on the accumulation of bile, which takes place during the long fast of the night, as but little bile passes into the duodenum except during digestion, so that this might be obviated by making the patient take a light supper on going to bed, or something to eat before getting up in the morning, or a glass of soda

water or Vichy water, or a good substitute for it made by dissolving thirty grains of bi-carbonate of potash in a tumbler of either cold or tepid water, and then adding five grains of citric acid, to be taken while effervescing.

You must distinguish this form of headache from another kind, which is caused by the presence of food in the stomach, and though in some cases coming on immediately after food is taken, yet mostly occurs about an hour after digestion has commenced, and continues during the whole of the process, until relieved by vomiting, either spontaneous, or excited by an emetic of sulphate of zinc or ipecacuanha, which is the best treatment, followed by a mercurial purgative, and small doses of rhubarb and magnesia continued for some days; but in all cases great attention must be paid to the quantity and quality of the diet.

One of the most common and constant symptoms of dyspepsia is a sense of *fullness* or distention of the stomach, coming on a short time after food, attended with a sense of constriction, as if the clothes were too tight, so that patients are glad to loose them, in order to get relief; and they are often much annoyed by *flatulence* and eructations of gas, with great rumbling of wind in the large intestines. If this comes on after food, it may be prevented by taking a pill of four grains of rhubarb with one of capsicum before meals; but if it comes on when the stomach is empty, give some carminative—as from thirty to forty drops of tincture of cardamoms, or compound spirit of lavender, or aromatic spirit of ammonia, in a little water, either plain or with a few grains of calcined magnesia. Constipation is another troublesome symptom, and the evacuations are generally dark, very fetid, often slimy or pultaceous. For this you should give some mercurial, combined with colocynth or rhubarb pill, to act on the liver and large intestines, so as to cause solid evacuations; for undigested substances may remain in the cells of the colon or cæcum for a long time, even though the bowels be moved daily; but be cautious of over-purgation, for patients are often anxious to take medicine, as it gives them temporary relief, by removing unhealthy secretions, whereas our endeavour should be to prevent their formation, which is best attained by improving the functions of the liver, the stomach, intestinal canal, and the skin, which last is generally dry and rough, or covered with a greasy perspiration. These patients often complain of a peculiar dry, prickly, pungent heat in the palms of the hands and soles of the feet, especially at night, while during the day they are chilly; and the face is pale, with a heavy, dull expression. The appetite may be variously affected—often diminished, or even totally absent, especially before breakfast; or there may be nausea and loathing at the very sight of food, while at other times it may be increased, or even ravenous. To restore or correct this, give an ounce of infusion of chiretta, or half a grain of sulphate of quini

(three times a day) half an hour before meals; but when there is disgust at food, you will find much benefit from pepsine, which generally causes an appetite; and in cases where severe pain or uneasy sensations are experienced after meals, depending on deficiency of the gastric juice, it is of much use. It should be taken immediately before meals, either in the form of powder dissolved in a spoonful of soup or sweetened water, or rolled up in a wafer, as recommended by Corvizar, Boudault, and Ballard, in doses of fifteen grains, or in drachm doses of "*liquor pepticus præparatus*," recommended by Dr. David Nelson, of Birmingham, which I believe is analogous to prepared rennet. Nausea and vomiting are sometimes very distressing symptoms, especially if there be much bilious fluid ejected; but you can generally give much relief by regulating the diet, acting on the bowels by enemata, and giving bicarbonate of soda in solution with dilute hydrocyanic acid, or in effervescence. Bismuth will be of use also, or creazote with aloes in pill. The tongue may present a perfectly healthy appearance, or be coated with a white fur, or be red at the tip and edges, or may be thick and oedematous, retaining the impression of the teeth; and patients often complain of a disagreeable clammy taste in the mouth, particularly in the morning, with a peculiar heavy odour from the breath. The urinary secretion varies greatly in dyspepsia: it may be scanty, of a deep red colour, and very acid, often depositing lithate of ammonia or lithic acid crystals; or it may be of a bright amber colour, very clear and acid, with a slight cloud at the bottom, formed of mucus, with minute crystals of oxalate of lime, sometimes visible to the naked eye if exposed to a bright light, but always to be seen under the microscope; or it may be of a high colour, and yet deposit a white sediment formed of phosphates, which is characteristic of a highly irritative form of dyspepsia; or it may be pale, and become alkaline shortly after being passed, depositing triple phosphate with phosphate of lime; or, finally, it may be passed frequently, and in great quantity, like pure water, when the patient labours under much nervous excitement.* In the first of these conditions, Dr. Prout recommends fifteen grains of bicarbonate of soda or potash to be taken three times a day, two or three hours after meals; while to counteract the oxalate of lime, he advises the nitric or nitromuriatic acid, from ten to twenty drops of the dilute acid half an hour before meals, in water or some bitter infusion. If the patient be much debilitated, give some preparation of iron about an hour after meals; and if there be much nervous irritability, Dr. Golding Bird recommends sulphate of zinc, in doses of a grain three times a day, made into a pill with extract of hyoscyamus or

gentian, and gradually increasing the dose up to five grains—a practice which I have seen attended with much benefit. If the urine be alkaline, with deposit of phosphates, you must try to improve the general health by good diet, wine, or brandy and water, tonic medicines, acids, quinine, or iron; and if the secretion of urine be pale, copious, and frequent, you should give valerianate of zinc, or equal parts of infusions of valerian and bark. Besides these symptoms which we may refer directly to the digestive organs, there are many others which we term sympathetic, or affecting distant parts—such as cough, palpitation, intermission of the pulse, anomalous pains in various parts of the body. A "stomach cough" may be generally distinguished from that depending on disease of the lungs by the uneasy sensation referred to the epigastrium, and by its being hard, loud, and coming on in paroxysms generally after meals, and early in the morning. Palpitation is often a very troublesome symptom, and gives much alarm to the patient, as he supposes he is a victim to disease of the heart. Dr. Abercrombie states that "the slightest, and perhaps the most common form, consists of a momentary feeling of rolling or tumbling motion of the heart, like that which is produced by a sudden surprise or fright; and it is accompanied by an intermission of the pulse, and sometimes by a feeling as if the heart were violently grasped." In other cases there are violent fits of palpitation, with a sense of tumult in the region of the heart, which recur frequently, with or without irregular action of this viscus; and sometimes there is an endocardial murmur, and dyspnoea, which may come on in paroxysms. An accurate physical examination will generally enable us to make our diagnosis, in which we will be assisted by the history of the case, "by the action of the heart being natural during the intervals between the attacks, by the symptoms being most apt to occur while the patient is at rest, especially after meals, not being increased by bodily exercise, but rather relieved by it, and by the result of treatment directed to the stomach." But you should remember that dyspepsia is often a result of tubercular disease of the lungs, or of organic disease of the heart; so be always careful in your examination, and cautious in your diagnosis. There is another class of symptoms which have reference to the nervous system, and also cause much distress—such as vertigo, noise in the ears, confusion of thought, defective memory, spectral illusions, irritability of temper, vacillation, despondency; in fact, a state of hypochondriasis, with a want of mental and physical energy often amounting to complete prostration, or rather a sense of debility often more distressing than actual weakness. I have not time to do more than merely enumerate these symptoms for you, and I must refer you for a full description to the admirable work of Dr. James Johnson,* who,

* A small quantity of sugar may be sometimes detected in the urine of dyspeptics; but I will consider this subject when speaking of diabetes, which may be almost considered as a peculiar form of dyspepsia.

* An Essay on Indigestion.

having been himself a martyr to dyspepsia, has graphically described them.

The causes of dyspepsia are numerous and various; they may be divided into physical and moral; of the first class, some act directly on the stomach itself, owing to errors of diet, whether in regard to quantity or quality. The diet may have been insufficient, either from poverty or prolonged fasting, or may have been rich, indigestible, and in too great quantity, or strong tea may have been indulged in. Dyspepsia may be sympathetically induced from disease in distant parts of the body, as we constantly see in the case of females, in whom it is often excited by some derangement in the uterine system, whether it be leucorrhœa, dysmenorrhœa, ulceration of the os uteri, chlorosis, hysteria, pregnancy, or be caused by lactation. We meet with it also in cases of tubercular disease of the lungs, in diseases of the kidneys and bladder, and also in cases of stricture of the urethra, in piles, and in protracted or exhausting hæmorrhagea. The second class of causes depend on the state of the nervous system, and mostly occur in persons of the upper classes of society, and of an irritable nervous temperament, usually a result of exciting or depressing passions; or in those who speculate largely, or who have met with reverses of fortune, and have suffered much anxiety of mind, particularly if the patient be of sedentary habits, and inclined to eat too much animal food, or indulge in pastry. The state of the blood, also, has much influence in causing dyspepsia, whether it depends on mere congestion, as we daily see in cases of diseases of the heart or in capillary bronchitis, especially when occurring in aged or debilitated persons; or whether there be actual impurity of the blood, from defective action of some of the excreting organs, as in cases of congestion or disease of the liver, when the elements of the bile are not properly eliminated; or if there be any disease of the kidneys which interferes with their functions, as we see in Bright's disease, when the uræa and other constituents of the urine are retained in the blood, and have even been detected in the matters vomited. Dyspepsia often depends on some fault in what Dr. Prout has termed secondary assimilation, when, though we cannot detect any visible structural change, yet that there is some defect in the nutritive processes is indicated principally by the various conditions of the urine, that I have already referred to. It is probable, however, that some changes occur in the pepsine glands which exercise an influence over the quantity and quality of the gastric juice; for, notwithstanding the important and accurate anatomical as well as microscopical researches of Dr. Handfield Jones and others, into the intimate structure of the stomach, there are, possibly, deviations from health of the gastric mucous membrane, and of the epithelial cells, which we have not yet detected, but which are the causes of deranged digestion.

ON THE ACTION OF THE AURICULO-VENTRICULAR VALVES OF THE HEART.

By W. T. GAIRDNER, M.D., Edin.;

Physician to the Royal Infirmary, Edinburgh; Lecturer on Practice of Medicine, &c. &c.

(Read before the British Association, August 31.)

My object in this communication is to call attention to certain points in the mechanical arrangement of the auriculo-ventricular valves; I shall leave the members present to draw, to a great extent, their own conclusions as to the bearing of these points on the physiology and pathology of the valves. The manner in which my own attention has been attracted to the subject was as follows. I have been for many years in the habit of observing that cases occurred, not unfrequently, in which indications appeared during the life of the patient of regurgitation through the mitral orifice, but in which, afterwards, the valves appeared by no means insufficient. In many of these cases there was, no doubt, some slight degree of thickening of the valves, or widening of the orifice; but, in some of them the amount of disease and of deformity appeared so trifling, as to necessitate the conclusion that the source of regurgitation was to be sought in the muscular structures, rather than in the orifice itself. Pursuing this line of inquiry I was led to the conviction that certain morbid conditions of the ventricle, and particularly dilatation of its apex, exercised a much more considerable influence on the condition of the valve than was commonly supposed; and, in particular, that the relative position of the carnea columnæ had not been sufficiently studied in relation to the action of the valve. In proof of this, I may mention that in some of the most recent and authoritative works on physiology these structures are represented in diagrams as being, during the ventricular systole, in a position which I believe to be totally inconsistent with the closure of the valve.

I will now proceed to demonstrate the true position, which was rightly apprehended by Bonillaud, when he described the insertion of the chordæ tendinæ into the fleshy columns, as the apex of a cone of which the valve formed the base. If the heart of a sheep or bullock be chosen, of which the left ventricle is in a state of firm tonic contraction, the ventricle being empty of blood; and if such a heart be cut into transverse slices, or opened in such a way as to show the relations of the large fleshy columns which connect the chordæ tendinæ with the opposite sides of the ventricle, it will be seen that the columns of opposite sides lie most accurately in apposition, and that the surfaces are fitted to each other with almost as much nicety as the opposite molar teeth of the upper and lower jaw. The effect of this arrangement is, that the contraction of the

apex of the ventricle completely obliterates the interspace between these columns, and gathers all the ends of the chordæ tendineæ into one single point in the middle of the ventricle. Nothing can be more beautiful and regular than this arrangement in the left ventricle: in the right it is, perhaps, not so perfect—at all events it is less easily demonstrated. Now, let it be remembered that the first act of the ventricular contraction is precisely this contraction of the apex, and the effect of the mechanism in question will become obvious. In fact, if the contraction of the heart be carefully observed in a cold-blooded animal, or even in an animal under artificial respiration, and when it is becoming slow, it will be seen that the contraction of the auricles is propagated, not to the ventricles in all parts simultaneously, but to the back part and apex first, and then to the conus arteriosus, or front and upper part of the ventricle. Accordingly, the systole of the conus arteriosus, or cavity, properly speaking, of the ventricle, is preceded by a movement among the fibres of the apex, which brings the columnæ carneæ, and therefore the tendinous cords of the opposite sides, into the closest possible apposition. Is this mechanism, or is it not, essential to the closure of the valve? That it is so, in all probability may be shown by an experiment on the left side of the heart. It is well known that John Hunter, followed by Dr. Adams, of Dublin; and Dr. Wilkinson King, of London, held the view, that the tricuspid valve was naturally an imperfect one. They admitted, however, that the mitral was a perfect valve, and might be made to act in the dead body. On repeating this experiment, however, I found that the competency of even the mitral valve was essentially dependent upon the condition of the ventricle. The moment that the ventricle became distended, so as to separate considerably the opposite sides of its apex portion, leakage of the valve began. I am by no means satisfied that the right auriculo-ventricular valve is, any more than the left, an imperfect one, in the normal state of the ventricle; but undoubtedly its competency is more easily overcome, and is not to be demonstrated after death in most instances.

PREPARATION OF INK.—Dr. Bley recommends the following method of preparing ink:—A decoction is made with a pound and a quarter of nut-galls, and as much hot water as will give five pounds of liquid after straining. Then four ounces of indigo powder is mixed with half a pound of sulphuric acid, the mixture left for twenty-four hours, then dissolved in five pounds of water and eight ounces of powdered chalk, and eight ounces of iron filings added. A part of the acid is neutralised by the chalk, and a part by the iron filings, forming sulphate of iron. The solution thus obtained, mixed with the decoction of nut-galls, gives ten pounds of ink, which does not deposit sediment or turn mouldy, and flows readily from the pen.

ON THE PRESENCE OF
ELASTIC PULMONARY FIBRES IN THE
SPUTA OF PHTHISICAL PATIENTS,
AS A CERTAIN SIGN OF THE EXISTENCE OF A VOMICA.

By J. L. C. SCHROEDER VAN DER KOLK,
Professor in the University of Utrecht.

Translated from the Dutch by

WILLIAM D. MOORE, A.B., M.B., T.C.D.,
Honorary Member of the Swedish Society of Physicians.

(Concluded from page 204.)

If we now, however, study a little more accurately the origin of a vomica, the importance of this sign will appear still more evidently; thus, it cannot be denied, as Rainey* has very correctly represented from nature, in his treatise above quoted, and as Vogel† also states, that the tubercular matter is deposited in the cavities of the lungs; I have, twenty years ago, stated this in my fasciculus, in consequence of microscopic investigations I then made.‡ This point, I have, however, now specially examined with the aid of an excellent microscope; the result of this examination, as well of tubercles in the lungs of men as of a horse, of two cows, and of a fine specimen in a dog, for which I was indebted to the kindness of my friend Professor Numan, was, that the tubercular matter had in all been deposited in the cavity of the pulmonary cells. This was exceedingly beautifully shown in the pulmonary tubercles of animals; thus these were kept a long time in spirit, whereby the tubercular matter was in many places condensed, and diminished in circumference, so that it had separated from the walls of the air-cells, which, with their peculiar elastic fibres, were seen very plainly to run through the tubercular matter, and to enclose it in the cavities of the cells; I could not observe tubercular matter in the interstitial space. If the tubercular matter begins thus to accumulate in the pulmonary cells, the originally round tubercular corpuscles, as Lebert also supposes,§ become by pressure oblong, angular, and irregular; I still found round corpuscles in cells adjoining tubercles, which were not completely filled. The vessels in the walls of the filled cells begin to close, probably in consequence of pressure, perhaps also partially from congestion in inflammation; the walls of the cells now receive no more blood and die; the tubercle begins to soften, and the cell-walls and elastic fibres, which are already dead, become separated from the still living portion and are expectorated; the sputa must thus bring with them these elastic fibres which exist in such great numbers in the walls of the cells; the greatest bulk of the sputa proceeds, however, no-

* On the minute structure, &c., in *Med. Chir. Trans.* 1845, p. 591., pl. v. fig. 4.

† *Icones*, Tab. xv. fig. 10, 11.

‡ *Observ. Anat. Path.*, Amst. 1826, p. 24, et seq. § *l. c.*, T. i. p. 353.

doubtedly, from the bronchi, and from the irritated and inflamed mucous membrane of these and of their ramifications, and the more extensively this inflammatory condition is spread through these parts, in so much greater quantity are the sputa excreted and expectorated. But in the commencement of the formation of a vomica the inflammation is as yet limited to a small spot in the lungs, and circumscribed; the sputa are, therefore, still expectorated in smaller quantity, as is well known from experience, than when a very large vomica is present; the elastic fibres are thus at first mixed with a smaller proportion of pus, they are less diluted and appear in greater number. But if a large vomica already exists in the lung, a sort of pyogenetic membrane appears not unfrequently to arise; the pus is then very abundant, but as this pyogenetic membrane covers the remaining cells, the progress of destruction does not always continue so rapid, and the number of evacuated fibres becomes less, while the latter are diluted by a greater quantity of pus, and become more difficult to find. This I observed in the sputa of a patient already far advanced in phthisis, wherein I found only few and very short fibres; and this is also, I believe, the reason why these fibres have not attracted more attention, since, in examining the sputa of a phthisical patient one usually selects cases in which the existence of phthisis is no longer doubtful, and where, consequently, extensive vomicae have already formed. Even in the sputa of this phthisical patient, who was in the last stage of the disease, I could sometimes find no fibres at all, though a couple of days earlier I had distinctly met them; hence it is, that the elastic fibres in a large vomica may be long before they are coughed up; they are thus, tenacious as they may otherwise be, more macerated, less coherent, and manifest themselves only as fragments. Oftentimes, however, I have met in such cases, and occasionally also in incipient phthisis, thin lamellæ of the mucous membrane of the air passages, with which the elastic fibres, and perhaps muscular fibres, and sometimes also vessels, were still connected. Once I found an entire layer of more deeply situated elastic fibres of the bronchi.

I believe, therefore, that from the foregoing we may infer that the elastic fibres appear in greatest number, and in the highest perfection, as indeed investigation has proved to me, in the commencement of phthisis and in the first period of a vomica, but in less quantity and in smaller fragments when the vomica is large; consequently, in them we possess a sign which is most decided exactly when the other aids to diagnosis still leave us in uncertainty, and when all hope of rescue has not as yet forsaken the sufferer; for the existence of a large vomica is usually recognizable with sufficient ease by other signs, to prevent any doubt being entertained upon the subject.

But when a vomica begins to heal, and soli-

difies, of which specimens are not unfrequently met with in dead bodies, and of which I also possess remarkable examples in my collection, the fibres should also cease to appear in the sputa, while the quantity of the latter should at the same time diminish. They are, therefore, not merely a sign of the existence of a vomica, but may also serve to indicate its greater or less progress, or indeed its cure. If the fibres have still retained their coherence it is a proof that the vomica is increasing, and that a greater portion of the pulmonary cells is, at the same time, expectorated. If they are smaller, and the quantity of sputa is considerable, we may infer the existence of a larger vomica. If they diminish in number, while the quantity of sputa also diminishes, they may, in connexion with the other phenomena, justify a more favourable prognosis. If many lamellæ of the mucous membrane of the air passages, or layers of elastic fibres of the bronchial ramifications occur, we may conclude that the latter are already attacked.

It might perhaps be supposed that these elastic fibres should be capable of solution in pus, and so be altogether wanting in the sputa, by which they should lose much of their value as a sign of the presence of a vomica. This is, however, not probable, for these fibres are of such a firm texture that they long resist destruction. I have found them unchanged in sputa which have been kept twelve days, and appear to have passed into acid fermentation. In this case, however, they are apt to become covered with granular matter (of which hereafter), whereby they appear thicker, but still retain their peculiar curved form. It is known that they resist the action of nitric acid, and even of caustic potash. Hence it follows that they can scarcely be absent from the sputa at the commencement or during the increase of a vomica, and that they are to be regarded as a very characteristic sign.

In order to find these elastic fibres in the sputa, it is necessary to select the whitest, least transparent, and most viscid portions. Fibres are never present in the clear mucus. Sometimes there are little white granules, or more solid circumscribed particles in the sputa; these should not be selected, as they usually consist, nearly exclusively, of fat; although they are, for the most part, regarded as portions of tubercular matter. A little of the opaque white viscid sputa is placed upon the object glass, and covered with a piece of very thin glass or mica, although the former is preferable, as there are often streaks in the mica, which, when magnified, may mislead. The sputa should then be pressed so flat as to appear merely as a very thin membrane, as otherwise the elastic fibres, on account of their opacity, cannot well be distinguished. The best mode is to examine them first with a low power, for example, one which magnifies about 200 times, as we can thus inspect a larger field, and find them more rapidly. They

may be distinctly enough recognised at that, or even a lower power. When they are once found, a 400 or 500 magnifying power is employed, to exhibit their peculiar course and connexion.

They are always recognised by their peculiar arched course, and their adherence; which arched course is so characteristic, that it is invariably visible, even in small fragments; hereby they are in all respects distinguishable from other little filaments which very often adhere to the glass, for example, in wiping it with a cloth. They are also extremely thin, and present somewhat dark sharp edges, one of which is usually, through the refraction of light, darker than the other. They mostly occur in bundles, either as oblong bundles, or completely united, so that the form of the pulmonary cells can still be distinctly recognised. If we find extensive coherent bundles, it is a sign that a considerable portion of a lobule has separated, and from their extent we can with sufficient accuracy estimate the quantity of the expectorated pulmonary cells.

Sometimes we meet fibres in the sputa which are completely studded with granules, and so swell to a considerable thickness. I suspected at first that this was the consequence of some destruction or change in the sputa, as I often met such granules in older sputa, until I met them also in recent sputa. They occur chiefly in the solid white parts, and appear to be caused by fat globules, which adhere to the fibres; these globules were dissolved by ether, and also by caustic potash, and I obtained the elastic pulmonary fibres again.

In order to show more clearly the connexion between those fibres in the sputa and their position in the lungs, I have thought it well to add the representation of some pulmonary cells, taken out of a healthy lung, prepared as accurately as possible, and magnified 200 times; and the more so because many have adopted the, in my opinion, very erroneous habit of drying, for the purpose, a portion of an inflated lung, and bringing thin layers of it under the microscope. By this much both of the form and distinctness of the fibres, the cell walls and their nuclei, is lost. Taking care to lacerate the tissue as little as possible, I placed a small portion of the lung in a hollow Oberhäuser's glass, moistened it with a little dilute acetic acid, and covered it with a thin piece of glass, so that the pulmonary cells might, without any pressure, float freely in the fluid. I thus observed the partitions of the cells with their elastic fibres, the very thin tissue constituting the walls of the cells and covering them, on which many nuclei were visible; and lastly, how some pulmonary cells belonging to the same lobule, intercommunicated, and were not merely attached to one stalk, as Reisseissen has represented. The partitions were in some parts only simple bands running from one wall to the other. On the walls of the cells also ran elastic fibres and vessels. Inflammatory globules often occur in the cells, particularly

in the neighbourhood of a tubercle, so that it may easily be imagined that if these cells were entirely filled with such globules or tubercular matter, the partitions must be compressed and destroyed. The thin membrane is then for the most part lost, and therefore occurs more rarely in the sputa, while the indestructible elastic fibres, when separated, are expectorated.* Finally as to the different colour of the sputa: the extremely yellow sputa are not necessarily always of the worst description, they usually contain a considerable quantity of fat. The sputa expectorated in a case of vomica, are for the

* Besides the tubercle above described, there is a second kind, distinguished chiefly by a cheesy appearance, and the presence of blacker pigment; these not unfrequently contain small pieces of bony substance. I have already described them in my *Observationes anat. pathol.* as probably originating in a morbid affection of the lymphatics, as I succeeded in filling a lymphatic with quicksilver which ran into such a calcareous tubercle, and there poured out some of the quicksilver. (*Observ. anat. path.* p. 81, *et seq.*) Subsequently I often succeeded in this experiment, of which I have many beautiful specimens. In one case I even met with a very large tubercle of nearly two centimetres in diameter filled with calcareous and soft cheesy matter; on filling the lymphatics I observed an entire network of them passing to this tubercle, in which a great portion of the quicksilver was effused. With the microscope I discovered that these tubercles are situated in the areolar tissue between the lobules; they here appear quite different; I saw no trace of cells remaining in them, but everywhere areolar tissue and pigment, which, as is well known, exists in the lymphatics of the lungs.

As the internal lymphatics of the lungs are as yet but little known, I think it not out of place here to state that I have often succeeded not only in filling the internal lymphatics of the lungs with quicksilver, but also in becoming better acquainted with their course; thus I found that the pulmonary artery is surrounded by a rich network of lymphatics, the preparation of which, however, I was not so fortunate as to preserve, for on cutting the branches of the pulmonary artery, which was almost unavoidable, the quicksilver escaped out of the lymphatics surrounding the vessel. Subsequently I met a very remarkable lung in a body, in which medullary fungus of the stomach and liver existed; all the lymphatics in the abdominal cavity, the lumbar plexus, a number around the pancreas, and even the thoracic duct were filled with a white medullary matter, which, according to the microscopic examination of my friend Dr. Van Leeuwen of this place, contained many large parent cells with smaller young cells. At the same time the lymphatics of the lung were filled with a similar white matter, very like the medullary fungus, and indeed so completely that it would be impossible, artificially, to fill them to the same extent. For the better preservation of the object I tried injecting them with quicksilver, which succeeded beyond all expectation, inasmuch that I saw both external and internal lymphatics admirably filled; on examining a portion under the microscope, I saw exceedingly beautifully how the lymphatics are distributed everywhere around the lobules in the areolar tissue, and how the pulmonary artery is surrounded by a rich network of lymphatics—many appear to run also in the neighbourhood of the bronchi. Hence it appears that there is a very great analogy between the pulmonary artery and the vena portarum: both carry venous blood, both are surrounded by a copious network of lymphatics, both have their arteries, in the lungs the bronchial artery, in the liver the hepatic artery, in the neighbourhood; so that perhaps a capsule of Glisson might be described as well on the pulmonary artery as on the vena portarum.

most part whitish and globular; in the case of a phthisical patient at the point of death, I found the sputa bluish, opaque, and loaded with numerous elastic fibres. I have observed these fibres, both in the floating and in the sunk sputa; usually in greater quantity in the white sunken portions. In the case of a very large vomica in far advanced phthisis, I found small fibres and fragments of the same in the white floating sputa; in the sunk sputa, and especially in some yellow parts of them, very many flat epithelial cells, among which were some of surprising magnitude, so that I at first thought they must be foreign admixtures; in the other white sunk ones were very many flat epithelial cells, such as occur in the cavity of the mouth and larynx, together with many oval tubercular cells similar to those represented by Lebert, also without nuclei, which Lebert, however, as we have seen above, assures us scarcely ever appear in the sputa.

The pavement epithelium occurs very often in the sputa, and of different shapes, sometimes oval, sometimes more roundish, square, and of unequal size. Although it is known that the air passages are covered with ciliated epithelium* and therefore this pavement epithelium ought not to proceed from them, I thought it worth while, once more, to examine the entire of the air passages with this object in view. I found in the sinues of the larynx among much ciliated epithelium, at the same time some oval pavement epithelium, such as often occurs in the sputa; the epiglottis was in great part covered with ciliated epithelium, among which was a very little pavement epithelium, mostly of small circumference and irregularly round and furnished with nuclei; the whole trachea and the bronchi to the finest ramifications of half a millimetre I found covered with ciliated epithelium, though of very unequal length; in general it was shorter in the finer branches. Among this ciliated epithelium were, however, some cells of pavement epithelium, but very small, of about the circumference of a pus-globule, so that it sometimes had the appearance as if we looked down on ciliated epithelium from above, from which, however, it could be distinguished by pressure. In the pulmonary cells themselves, I could discover no ciliated epithelium, but only the most extremely thin membrane, investing the walls of the cells and studded with many nuclei; occasionally I succeeded in seeing on it very thin pavement epithelium cells of small circumference. Hence it appears that the larger forms of pavement epithelium cells, as well the oval as the irregularly quadrangular which often occur in the sputa, are not derived from the lungs, but proceed from the mouth and throat, and are ejected with the sputa.†

* Henle, *Alg. Anat.* page 246.

† I must take this opportunity of observing that I can by no means agree with Rainey (*Med. Chir. Frans. loc. cit. p. 584.*) that the mucous membrane invests only the bronchi and their finest ramifications, but is wanting in

Further pavement epithelium must not be confounded with laminae of the internal membrane of the bronchi or cells; the latter are usually covered with fibres and irregularly and angularly torn, whereby they are easily distinguished from pavement epithelium; I have, however, also found them pure without any adherent fibres, but ordinarily these fibres, or impressions of subjacent muscular fibres, are very well marked. These membranes occur in the sputa, and may be easily recognised, and the inference drawn that the ramifications of the air tubes are already destroyed by the progress of the vomica.

Care should however be taken, in examining the sputa, to bear in mind the possibility of the occurrence of foreign admixtures. Thus in sputa only two days old, I found fibres, which, from their greater length, I was at first sight disposed to look upon as being derived from the bronchi or larynx, these parts having recovered from what I suspected to be laryngeal phthisis; on accurate examination I found that they were formed by a conferva which had been developed in that short time—such a conferva will be distinguished from elastic fibres both by its different course and by giving off branches, by the button-like extremities of the latter, and by the little cells apparent in the cavity of the conferva. The conferva is developed chiefly in places where rather more fat has accumulated in the sputa, or has been ejected with fragments of food.

In like manner, crystals have occurred to me in very great quantity, resembling those of nitrate of potash, and long puzzled me, as the patient used no nitre, until I discovered a small fragment of muscular fibre, from which I inferred that he had probably eaten salt meat, to which nitre is some

the cells internally, whereby he purposes to explain the difference between inflammation of those parts in bronchitis and peripneumonia, mucus alone being secreted in the former case, and plastic lymph from the pulmonary cells in the latter. Although the most minute branches of the bronchi are more opaque and appear to be invested with a thicker membrane, which Rainey also delineates (Pl. v., fig. 1.), it seemed to me that this opacity and whiteness is caused by a thick subjacent layer of muscular fibres, which here run very regularly for the most part in a longitudinal direction, and are plainly distinguishable from the elastic fibres by their straighter course, their greater thickness and the regular bundles which they form. Between these muscular fibres and the mucous membrane still thinner fibres are placed, which appeared to me to be fibres of connective tissue mixed with elastic fibres; however, I nowhere observed the muscular fibres to pass into the cells, so that I infer they do not exist there. From the inner surface of the bronchi I have often separated a thin membrane, which under the microscope was in no respect distinguishable from the membrane of the cell walls, and in tenuity quite equalled them; on it however nuclei were less evident, sometimes I could not at all discover them, while several straight impressions of the subjacent muscular fibre further distinguish this membrane from that of the pulmonary vesicles or cells. Whether the deficiency of nuclei on it is connected with the absence of pavement epithelium from the ramifications of the bronchi, I cannot decide.

times added to heighten the colour, and which had remained between his teeth.

Should these remarks and observations tend to direct the attention of practitioners more closely to the important point they refer to, and by the speedy recognition of the presence of an incipient vomica, to inform them at an earlier period of their patients' state, when it is often overlooked and rescue is still possible, I should esteem myself happy.

Selections from British & Foreign Journals.

On a mode of improving Cows' Milk, and rendering it more easy of digestion for healthy and diseased Children. By Dr. GUMPRECHT, of Hamburg.

Dr. Gumprecht prefaces his observations by remarking upon the fact that milk often disagrees with children, producing indigestion, acidity, flatulence, colic, diarrhoea, &c., &c. In consequence of this, it has been proposed to improve it by the addition of water and sugar of milk, which experience has proved to have imperfectly attained the object in view. Reflecting on the effect of salt in rendering the food for adults not only more palatable, but also more digestible, increasing the activity of the glands of digestion, and rendering the albuminous substances and fat soluble in the fluids of the stomach, Dr. Gumprecht was led to the idea of adding salt to milk, both for weaned and older children, with the result of not only preventing the derangement of digestion, but moreover of removing them in cases where they previously existed. No author who has written on the nutriment of weaned children has spoken of this most useful addition to milk; but a Dutch physician mentioned to Dr. Gumprecht, in conversation, that in his practice in Holland he had frequently added a little salt to milk for weaned children with most satisfactory consequences.

In the rural districts in Holland, salt is frequently added to the fodder for pigs and cattle, for the purpose of preventing diarrhoea, which so often exists in consequence of imperfect digestion, and this suggested the adding salt to milk, not merely for healthy children, but for strumous children and such as are affected with worms. Dr. Gumprecht quotes a passage from L. Nussdorff's *Lehrbuch der Gesundheitspflege*, 1856, on the importance of salt in the nutriment of man and animals.

With regard to the quantity of salt which should be added to the milk, it must depend on the age of the child. To render cows' milk like human milk, it should be boiled and skimmed, and a little sugar of milk and salt added.—*Journal für Kinderkrankheiten.*

Der Abdominal Typhus der Kinder. Von EDMUND FRIEDRICH, Dr. Med. und Practischen Arzte in Dresden.

Before proceeding to notice the labours of Dr. Friedrich, it may be expedient to refer to the name of the disease which forms the subject of the memoir, inasmuch as *abdominal typhus of children* sounds strangely in English ears.

The disease which is known by this name in Germany, from its reputed resemblance to the abdominal typhus or "typhoid fever," of adults, was first described by our own countrymen, Hamilton and Underwood, and has received from authors a great variety of designations, such for example, as *Febris meserica*, *Febris remittens infantum*, *Febris gastrico-nervosa*, *Enteritis folliculosa*, *Ileitis*, &c. The author of the present essay has had vast opportunities of investigating the diseases of children in the Institution at Dresden, where he has been assistant physician, the results at which he has arrived being deduced from the examination of 275 cases of abdominal typhus, and the *post-mortem* appearances noticed in ten cases which terminated fatally.

He offers his essay as a small contribution to the scanty materials collected by German and French physicians on the subject, and dwells on its importance, not merely to the physician devoted exclusively to the diseases of children, but no less to the ordinary practitioner.

We shall give, briefly, Dr. Friedrich's conclusions.

Abdominal typhus is not a rare disease, and it appears sometimes in a sporadic and sometimes in an epidemic form. The epidemics occur in limited districts, and adults either altogether escape, or only a few are attacked. Boys are more frequently the subjects of the disease than girls.—The mortality is not so great in the disease of children as in adults. With respect to age, it is rare during suckling, it becomes more frequent from the second year, and most frequent from the sixth to the eleventh year; from this age to that of puberty there is again a diminution of its frequency. The period of life when the mortality attains its maximum is from the first to the fourth year. A sort of antagonism exists between scarlatina and this disease, for when an epidemic is present, the other disease disappears, or is of rare occurrence. In addition to the predisposing influences of age and sex, the causes of abdominal typhus are misery, uncleanness, unsuitable food, and above all, bad air, and damp, ill-lighted habitations; sudden changes of habits of life and epidemic constitution may also be enumerated. The influence of contagion is very doubtful. Scrophulosis does not seem to have any power in causing the abdominal typhus of children. Of the symptoms of the abdominal typhus of children, the most important are those appertaining to the intestinal canal, and the cognate organs, as diarrhoea, meteorismus, en-

larged spleen, fever, rapid respiration and bronchial catarrh, &c., &c. are constant symptoms. Hæmorrhage from the bowels is of such rare occurrence and so unimportant at the outset of the disease, that it is evident no marked congestion can precede the local lesion. Rigors so frequent in adults seldom usher in the disease in children.

Symptoms referable to the nervous system, viz. delirium, somnolency, &c., are very frequent, but not very intense; of the exanthema, roseolæ are the most frequent; papulæ are not often seen—late in the course of the disease the miliary form is observed. The kind and extent of the exanthem are independent of the intensity of the disease.

The duration of the abdominal typhus of children independent of the premonitory stage, differs according to the severity of the case, and may vary from sixteen days to some months. In severe cases, complications and sequelæ appear, which retard the complaint or even cause an unfavourable issue.

Relapses are rare; some complications are out of proportion less common in children than adults; among these may be enumerated, parotitis, phlebitis, hæmorrhage in general, especially hæmorrhage from the intestines. The unfrequency and the little danger which generally attends the latter is clearly due to the rarity of the formation of typhus ulcers. The ordinary course of abdominal typhus of children is to terminate in recovery, with, in general, a short convalescence, and this is promoted by the comparative immunity from consecutive affections which are so dangerous in adults, and often even fatal, as tuberculosis, gangrene, ulceration of the intestines, affections of the mesenteric glands, &c. As to diagnosis in the abdominal typhus of children, we are almost exclusively directed to the objective symptoms, among which, as the most important, are the enlargement of the spleen; next the roseolæ; the high temperature of the skin, the prevailing epidemic, the diarrhoea, meteorismus, abdominal pains, ilio-cæcal gurgle, bronchial catarrh, cerebral symptoms, &c. &c.

If the diagnosis is not quite certain in the first days, the progress of the disease and the gradual development of symptoms will by degrees render it so. The pathological changes in the abdominal typhus of children, present the same varieties and the same constant conditions as in adults; of the latter enlargement of the spleen may be mentioned. Ulceration of the peyerian glands is rare, generally only a few glands are infiltrated, which, either by absorption or by the rupture of the follicle and the effusion of its contents into the intestine, return to their normal state without the formation of a cicatrix. The rupture of the follicles and their effusion into the intestinal canal only take place in a very limited extent. Of extreme rarity is the formation of ulcers in the mucous membrane of pharynx, œsophagus, trachea, &c.

As to the treatment: conformably to experience,

the best is the expectant, regard being paid to the prophylactic, dietetic, and symptomatic states. The disease cannot be cut short. Moderate doses of calomel given from the fifth to the eighth day appear to exert a favourable influence on the progress of the disease. Under all circumstances, the strength of the child is to be supported, and at an early period suitable nourishment should be administered.—*Journal für Kinderkrankheiten.*

EXCISION OF THE CLAVICLE.

By JAMES SYME, Esq.,

Professor of Clinical Surgery in the University of Edinburgh.

Agnes W., æt. 20, from Glasgow, was admitted into the hospital under my care on the 27th of February last, with the view of obtaining relief from a tumor on her left shoulder, firmly attached to the clavicle and acromion process of the scapula, but not interfering with the movements of the joint. It was about the size and form of a cocoa-nut divided longitudinally, and of a reddish colour, especially at the most prominent part, where a puncture had been made some time before. In addition to these unpromising characters, the consistence, which was soft throughout, and in some parts almost fluctuating, coupled with the fact that only five months had elapsed since the swelling commenced, led me, at first sight, to think very unfavourably of the case. Before deciding against interference, however, I considered it proper to make a more careful examination, which induced me to entertain some hope of being able to save the patient, who had no other complaint, and seemed to be in good general health.

On tracing the clavicle from its sternal extremity towards the tumor, I felt that it was distinctly expanded at the base of the morbid growth, which I therefore concluded had originated from the bone, and not simply adhered to it. But, having long taught and practised upon the principle that osteo-sarcomatous tumors never extend their roots beyond an articulation, and as the clavicle is separated from the acromion process by a perfect joint, I felt quite sure that if the disease had commenced in the former, it would not implicate the latter bone. Then, as the shoulder-joint moved with undiminished freedom, I felt sure that the tumor could not have acquired any intimate connection with the capsular ligament, from which, indeed, it would be separated by the bursa that lies under the deltoid muscle; so that there seemed to be no insuperable obstacle in the way of removal, while the patient's healthy aspect afforded encouragement to hope that the disease might not prove to be of such a malignant disposition as its appearance threatened. Being confirmed in these views by further observation and

reflection, I proceeded to perform the operation on the 18th of March.

An elliptical incision was made from the middle of the clavicle backwards over the most prominent part of the tumor, so as to include within its curves the portion of integument that would have

proved redundant if allowed to remain. I then reflected the flaps, and exposed the clavicle at a little distance beyond the expanded part, where I divided it by cutting-pliers. A hook being next inserted into the extremity of the bone, and con-signed to an assistant, with instructions to hold it



steadily upwards, I carefully divided the connections of the tumor by dissecting upon the surface,—not parallel with it,—so as to complete the operation without inflicting any injury on the neighbouring parts, more particularly the capsular ligament, which was, nevertheless, denuded over a large portion of its extent. The wound healed quickly under ordinary treatment, so as to be completely and soundly cicatrised on the 22nd of April, when the patient was dismissed with less deformity and inconvenience than could be imagined by any one who has not seen how little disturbance results from removing the clavicle, even throughout its whole extent.

The tumor was of a globular form, having completely expanded the clavicle to its extremity, without in the slightest degree affecting the acromion, and measured four and a-half inches in one direction, by three and a-half in the other. When divided, it was found to present unusual characters, as will appear from the following account, for which I am indebted to Mr. Lister:—

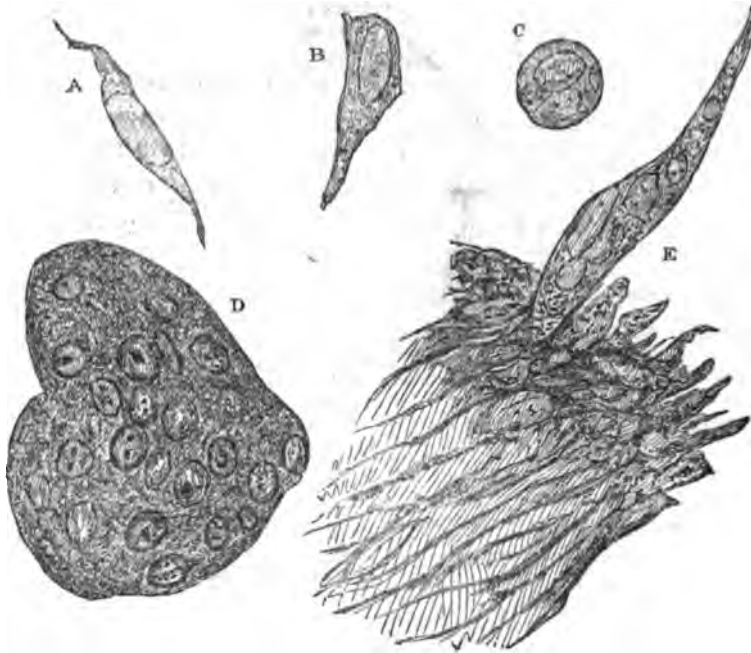
The accompanying figure represents, on a reduced scale, the appearance of the tumor cut

through, so as to divide longitudinally the sound portion of the clavicle removed along with it. The bone is seen to become expanded and thinned till it loses itself upon the investing capsule, which appeared to consist of the periosteum greatly thickened, and contained some scales of osseous material. The interior of the growth was made



up, for the most part, of a multitude of cysts, varying in size from a bantam's egg to a millet seed, and containing bloody or serous fluid. Their walls, which presented great differences in thickness, were composed of a pretty firm "fleshy" substance, slightly granular in section, varying in tint from yellowish grey to crimson, and yielding, when scraped, a little reddish, but *not* creamy juice. In this basis were scattered numerous small spicula of bone, and also some larger masses of the same material, particularly in the more solid parts of the tumor. This description corresponds very closely with the account given by Mr. Paget, in his *Lectures on Surgical Pathology*, of a case of cystic myeloid disease. The term, myeloid, has been recently applied by this author to a class of growths of benign tendency, formerly

confounded either with fibro-cartilaginous or cerebriform tumors, according to their consistence, but which he has shown to be made up of elements similar to those met with in "intra-membranous" ossification, and specially characterised by the presence of large cells, each containing a multitude of small nuclei, quite distinct from anything seen in cancer, and only found elsewhere in the medullary substance of growing bones, as first observed by Kölliker. In the present case, the microscopical characters also corresponded accurately with Mr. Paget's description. The fleshy substance above mentioned proved to be a very crude form of fibrous growth, composed chiefly of more or less regularly formed fibro-plastic corpuscles, such as are represented in figures A and B. In addition to these elements, were numerous



well-marked myeloid cells, of which figures C and D are about the smallest and largest that I met with. Figure E shows one of more elongated form projecting from a portion of the rudely fibrous stroma. In confirmation of the view, that myeloid growths are allied to developing bone, I may mention that both the fibro-plastic corpuscles and their mode of ossification in this tumor were precisely similar to what I happened to have, at the same time, the opportunity of observing in the new material which had been effused for the repair of loss of substance in a human bone.—*Edinburgh Medical Journal*.

NOTE.—We have to acknowledge the kindness of Dr. Syme, and of the Editor of the *Edinburgh Monthly Journal*, in allowing us to make use of the woodcuts illustrative of this valuable communication.

STATISTICS OF INSANITY.

PER-CENTAGE OF RECOVERIES AND MEAN ANNUAL MORTALITY.

The per-centage of recoveries at Bethlem during the decennial period ranges at 54.19, and the mean annual mortality at 6.37; while for the two years ending December 31, 1855, Dr. Hood states their relative results to be 48.05 per cent. of cures to an annual mortality of 8.27.

From a table by Dr. Daniel Tuke, in the "Psychological Journal," July, 1854, and quoted by Dr. Hood, it appears that the average results, drawn from the statistics of various asylums in England, Holland, France, Germany, &c., stand in the relation of 39.74 per cent. recoveries on the admissions, and a mean annual mortality of 10 per cent.

APPOINTMENTS.

THE NAVY.

ADMIRALTY, SEPTEMBER 15.

Surgeon John Gunn, to the Cyclops. Assistant Surgeon F. Hardinge, to the Impregnable, for Plymouth Hospital.

THE ARMY.

WAR OFFICE, PALM MALL, SEPTEMBER 18.

7th Dragoon Guards—Assistant Surgeon Edward M'Gill, M.D., from the Staff, to be Assistant Surgeon.

1st Dragoons—Assistant Surgeon Spencer Boyd Gibb, M.D., from the Staff, to be Assistant Surgeon, vice Sherlock, appointed to the 8th Light Dragoons.

8th Light Dragoons—Assistant Surgeon Henry Sherlock, from the 1st Dragoons, to be Assistant Surgeon, vice Hulseberg, appointed to the 1st Foot; Assistant Surgeon Thomas Rudd, M.D., from the Staff, to be Assistant Surgeon.

17th Light Dragoons—Assistant Surgeon George Carleton Clery, from the Staff, to be Assistant Surgeon.

5th Foot—Staff Surgeon of the Second Class Wm. Kilner Swettenham, M.D., to be Surgeon, vice Docker, appointed to the Staff.

18th Foot—Assistant Surgeon Andrew Mather Porteous, M.D., from the Staff, to be Assistant Surgeon, vice Ryall, appointed to the 86th Foot; Assistant Surgeon Frederick Ffolliott, from the Staff, to be Assistant Surgeon.

51st Foot—Assistant Surgeon John Ffolliott, from the Staff, to be Assistant Surgeon, vice Kilgour, appointed to the 9th Foot; Assistant Surgeon George Samuel Burnside, from the Staff, to be Assistant Surgeon.

67th Foot—Assistant Surgeon Charles Augustus Shiell has been permitted to resign his commission.

94th Foot—Assistant Surgeon James Greig Leask, M.B., from the Staff, to be Assistant Surgeon.

96th Foot—Assistant Surgeon William Collis, from the Staff, to be Assistant Surgeon.

HOSPITAL STAFF.

Inspector-General of Hospitals, with local rank, Charles Maclean, M.D., to be Inspector-General of Hospitals.

Deputy Inspector-General of Hospitals William Bell, M.D., to be Inspector-General of Hospitals, with local rank, vice Maclean, who retires upon half pay.

Staff Surgeon of the First Class James Guy Piers Moore, from half pay, to be Staff Surgeon of the First Class.

Surgeon Edward Scott Docker, from the 5th Foot, be Staff Surgeon of the Second Class, vice Swettenham, appointed to the 5th Foot.

THE ARMY.

WAR OFFICE, PALM-MALL, SEPTEMBER 25.

60th Foot—Assistant Surgeon John Matthew Biddle is permitted to resign his commission.

94th Foot—Assistant Surgeon John Wallace, from the Staff, to be Assistant Surgeon, vice Fitzgerald, appointed to the Staff.

2nd West India Regiment—Assistant Surgeon Edward Joseph Crane, from the Staff, to be Assistant Surgeon, vice Clutterbuck, appointed to the Staff.

HOSPITAL STAFF.

Inspector-General of Hospitals, with local rank, Daniel Scott, M.D., to be Inspector-General of Hospitals.

Deputy Inspector-General of Hospitals James Barry, M.D., to be Inspector-General of Hospitals, with local rank, vice Scott, who retires upon half pay.

Assistant Surgeon James Edmund Clutterbuck, M.D. from the 2nd West India Regiment, to be Assistant Surgeon, vice Hatchell, promoted to the 60th Foot.

Assistant Surgeon Francis Lewis Fitzgerald, from the 94th Foot, to be Assistant Surgeon to the Forces, vice Wallace, appointed to the 94th Foot.

To be acting Assistant Surgeons, Robert Dade, Gent.; Harvey Rowe, Gent.

DEATHS.

The following Medical Officers have perished in the disastrous revolt in India:—

Dr. Carl Buch (Bareilly), Dr. John Macdowall Har. Dr. and Mrs. E. M. James (Augur), Dr. John Kirk (Assistant Surgeon), Dr. Robert Lyell (Patna), Mr. James Graham (Superintending Surgeon), Mr. Henry Hawkins Bowling (Surgeon) Mr. John Pierce Bowling (Assistant Surgeon), Mr. Kinloch W. Kirk, (Surgeon), Mr. Moore (Surgeon 60th Rifles), Mr. Anthony Dopping (Assistant Surgeon), Mr. Joseph Fayrer (Assistant Surgeon), Mr. John Colin Graham (Assistant Surgeon), Mr. George Hanabrow (Assistant Surgeon).

September 25, at Mount Bellew, after a lingering illness, J. E. Butler, Esq., M.D., sincerely regretted.

BOOKS RECEIVED.

Transactions of the Cork Medical and Surgical Society. Dublin, 1857.

Notes on the Cholera at Varna, in 1854. By George Mackey, M.D. Edinburgh, 1857.

COMMUNICATIONS have been received from Dr. Jamison; Dr. McClinton; R. Lewis, Esq.; G. Philip and Son; Dr. Armstrong, Cork; Dr. O'Neill, Lincoln; Dr. Minchin; Dr. Frazer; Dr. S. Hobart; Dr. Johnston, Belfast.

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ON BRONCHIAL PHTHISIS.

By ROBERT MAYNE, A.B., M.B.,

Lecturer on Practice of Physic at the Carmichael School of Medicine, and Physician to the Hospitals of the South Dublin Union Workhouse.

Bronchial Phthisis, or Glandular Phthisis, is the name used by modern pathologists to denote a disease in which the lymphatic glands at the bifurcation of the trachea, and at the roots of the lungs, have undergone the tubercular degeneration; the glands in the posterior mediastinum, and those in the anterior mediastinum, very generally participating likewise in the mischief.

To judge from my own experience I should say that *true* bronchial phthisis is a very rare disease. In ordinary pulmonary consumption, no doubt, the bronchial glands are frequently tubercular, as every one conversant with thoracic pathology must admit, but to find the bronchial glands in an advanced stage of tubercular degeneration, *and the lungs at the same time perfectly healthy*, is, I believe, a very uncommon event, and yet to such a condition alone is the term bronchial phthisis fairly applicable.

The pathology of bronchial phthisis may be very briefly disposed of. As the tubercular deposition goes on in the bronchial and mediastinal glands, these bodies gradually increase in size, so as sometimes to assume incredibly large dimensions; a yellowish cheesy material constitutes the principal part of their bulk; after a time this material may soften, just as tubercle does elsewhere; or, like tubercle in other situations, it may undergo the calcareous transformation and remain afterwards comparatively inert.

To those who reflect upon the complicated anatomical relations of the bronchial and the mediastinal glands, it cannot be a matter of surprise that these bodies, when enlarged, should produce signs and symptoms, physical as well as vital, of the utmost diversity. Sometimes they compress the neighbouring bloodvessels, and when the superior *vena cava* happens to suffer in this way, its tributaries may become enlarged, and the soft parts from which those tributaries arise may become

oedematous, and hence the congested face, the purple lips, and the swollen features observable in such cases. Sometimes the pulmonary veins come in for an undue amount of pressure, and then oedema of the lungs, or even pulmonary hæmorrhage, the direct results of an obstructed pulmonary circulation, may occur; the pulmonary arteries, in consequence of their superior elasticity, usually escaping the effects of the compression. Sometimes the bronchial tubes, unable, notwithstanding their elasticity, to resist the "pressure from without," have their sides indented and their calibre diminished by the encroachments of the enlarged glands; when this happens, the volume of air transmitted through the bronchial tubes in respiration, becomes, of course, notably diminished, and then characteristic auscultatory phenomena may ensue; nay, even the œsophagus itself has been known to suffer severe compression from the enlarged glands in its neighbourhood, and then dysphagia, more or less urgent, according to circumstances, has been the result.

Still more remarkable consequences may follow when the tubercular material deposited in the bronchial or mediastinal glands softens; for in that condition it may make its way into the air passages, producing in its progress marked pulmonary irritation, or it may burst into the pleura, causing a rare form of empyema, or finally it may occasion *in transitu* erosion of the coats of one of the large pulmonary vessels, and frightful pulmonary hæmorrhage as the result.

Examples of all these complications have been collected with incredible assiduity by some of the French writers, particularly Barthes and Rilliet.

By far the most remarkable symptoms, however, connected with bronchial phthisis, are those which result from the irritation propagated by the enlarged glands to the neighbouring nerves. The pneumogastrics, from their position within the chest, are the most exposed to this injurious influence; and so important are the functions over which these nerves preside, that any undue pressure exercised upon them, or any extraordinary irritation propagated to them, is very likely to eventuate in serious mischief.

The following case illustrates many of the peculiarities of this rare disease:—

John Traynor, aged four years, a deserted child, was admitted into the hospital of the South Dublin Union Workhouse, in the month of March, 1856.

At the time of his admission he was in a state of the most deplorable destitution, being badly clothed, and having evidently been very insufficiently fed. He was at the time of his admission labouring under diarrhoea. Under the influence of suitable remedies and a well-regulated dietary, the diarrhoea gradually improved, and his flesh and strength once more returned; but during the ensuing autumn he was attacked with measles, from the effects of which he never afterwards recovered.

On the decline of the eruption, diarrhoea (more intractable than ever) set in; the stools were ochry in colour and most offensive; an insatiable thirst tormented him; his abdomen became swollen, and his flesh began once more to decline. He struggled on in this way with little apparent change, until the 14th of December, when my attention was particularly directed to him by the nurse, who remarked "that he snored in a very extraordinary manner during his sleep, although his breathing was free from the slightest stertor or other unnatural sound so long as he remained awake." For a considerable time after this report was made to me, I watched this child daily in my rounds without observing anything abnormal in his breathing; at length, however, "the snoring-breathing" occurred during the day as well as during the night, whilst he was awake as well as whilst he was asleep, and I was then enabled to judge of it for myself. The noise resembled very closely the whoop in pertussis, and occurred during inspiration only. Each inspiration was sonorous, and lengthened, and laboured, whereas each expiration was perfectly free, perfectly noiseless, and in every way perfectly normal. It was calculated that each inspiration was in point of duration nearly four times as long as the corresponding expiration.

On hearing this extraordinary breathing, my first impression was that the brain was in fault, but on the most careful examination I was unable to detect any satisfactory indications of cerebral disease. The child's voice was nearly perfectly natural; indeed he spoke without hoarseness, and this led me to look beyond the larynx also, for the source of the mischief.

On stripping the chest two remarkable circumstances were observed: 1st, the superficial jugular veins, and some of the superficial thoracic veins (tributaries of the superior cava) were unusually turgid. 2nd, at each effort at inspiration, the lower ribs at both sides of the chest were drawn forcibly inwards, presenting a striking contrast to their motion in healthy respiration.

From the distended condition of the thoracic veins, and the distended condition of the jugular veins, it was plain that, from some cause or other, the superior cava was obstructed. From the for-

cible inversion of the inferior ribs during inspiration it was inferred, that by some cause or other the due dilatation of the lungs in inspiration was prevented, and that consequently the diaphragm, unable to produce its ordinary effects upon the lungs, reacted abnormally upon the ribs. A precisely similar phenomena is sometimes observed in croup, and may be explained on the same principles.

On a careful stethoscopic examination of the chest the following particulars were noted:—

The percussion sounds generally over the chest were natural, but to this there was an exception at one spot, and at one spot only. *The middle sternal region was decidedly dull, the dullness extending equally to either side.* The dull part was situated too high to have been produced by the heart; it occupied the middle line too exactly to have been the result of disease affecting either lung exclusively.

On auscultation the respiratory murmur was found much modified; over a large portion of the front of both lungs, in the neighbourhood of the dull region, it was tubular, that is to say, the air on entering the lungs sounded to the ear exactly as if it were passing through a constricted tube deep in the chest. Elsewhere in front; and all over the back of both lungs, the respiratory murmur was feeble, but without anything of the tubular character. There were no rales audible anywhere.

On several occasions the boy complained of some difficulty in swallowing. Fluids used to stop in their passage through the œsophagus, after which they regurgitated through the mouth and nostrils, producing considerable distress; these latter symptoms, however, were only occasional.

On reviewing this case carefully, it seemed probable—

1st, that the principal mischief was situated in the chest.

2nd, that whatever its nature, it had obstructed the superior cava, produced a dull sound over the middle portions of the sternum, impeded the admission of atmospheric air into the lungs, and somewhat injuriously affected the œsophagus.

An aortic aneurism might have produced very similar symptoms, but then an aortic aneurism would scarcely have occurred in a boy four years old.

An enlarged thymus gland (thymic asthma) or enlarged bronchial and mediastinal glands (bronchial phthisis) were the most likely causes of the mischief. The probabilities appeared to preponderate in favour of the latter explanation, because the boy's history from first to last seemed to point to a scrofulous taint: his symptoms had originated in measles, the fruitful parent of organic scrofulous diseases; he had the enlarged belly, the general emaciation, the chronic diarrhoea so common in the strumous cachexia of childhood; and as if to clear up a doubtful diagnosis, a mass of scrofulous glands, the character of which could not for one moment be doubted, had lately appeared above the right clavicle.

For weeks this boy continued to all appearance without any very manifest change. I sometimes thought that the tubular breathing in front was less distinct; this, however, was uncertain; on several occasions he was reported by the nurse to have had, during the night, sudden attacks of extreme dyspnoea, in which suffocation seemed imminent. His strength declined daily, his playfulness and good humour never forsook him. At length, towards the latter end of February, he died suddenly in a paroxysm of dyspnoea.

The *post-mortem* examination was made about twenty-four hours after death. The brain was healthy. On raising the integuments from the neck (which was done with great care), a large mass of scrofulous glands was found in the right supra-clavicular triangle. They were of a greyish white colour, and contained a large quantity of cheesy material, none of them, however, had suppurated. Beneath the clavicle and under cover of the great pectoral muscle, another mass of enlarged glands was discovered, some of which had softened and contained scrofulous pus.

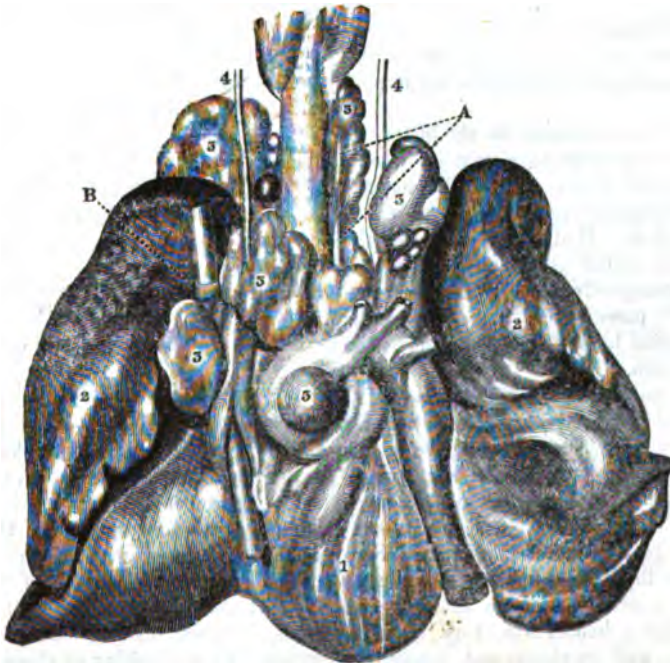
The lungs, which collapsed very imperfectly, were free from tubercular deposit, not a single tubercle being found in their parenchyma. When the sternum was raised, a huge mass of enlarged glands came into view, filling up to a considerable extent the anterior mediastinum, and encroaching besides both upon the pericardium and upon the roots of the lungs. The posterior mediastinum also contained a number of glands similarly diseased, although neither so numerous nor so bulky as those in the anterior mediastinum. The dia-

mond-shaped space comprised between the bifurcation of the trachea and the branches of the pulmonary artery, was occupied by glands in precisely the same condition. The superior cava, in its course to the right auricle of the heart, was distinctly compressed between two masses of diseased glands. A large scrofulous gland rested upon the aorta in its first stage; two or three others were fairly imbedded in the walls of the oesophagus. The bronchi in their course towards the roots of the lungs, were nearly surrounded by them, and the bronchial tubes, as they passed into the parenchyma of the lungs, were beset with them. Everywhere the structure of these glands was the same, they were white in colour, cheesy in consistence, but they contained no purulent matter.

On tracing down the great nerves into the chest, I found that the phrenics reached the sides of the pericardium without suffering any compression from the glandular swellings, but the pneumogastrics were each so much entangled in the enlarged glands, that it was almost impossible to follow satisfactorily the branches which constitute the pulmonary plexuses. A large chain of strumous glands also accompanied the left recurrent nerve in its course up the neck, entangling the nerve in such an intricate manner as to render its dissection difficult; the nerve itself also appeared rather wasted.

In the abdomen some of the mesenteric glands were affected by a similar disease. The lining membrane of the small intestine, near its lower extremity, was ulcerated, and in characters these ulcers resembled phthisical ulcers.

The wood-cut, after a drawing by Mr. Connolly,



1. The heart. 2, 2, The lungs. 3, 3, 3, 3, 3, 3, Enlarged glands.
4, 4. Right and left pneumogastric nerves, passing through the midst of diseased glands in the chest.

A. Left recurrent entangled in the enlarged glands.
B. Superior cava passing between two glandular masses, 3, 3.

represents the superior cava in its descent more or less compressed by these glands, the pneumogastric and left recurrent nerves entangled in them, and the air passages largely in contact with them.

The larynx presented none of the pathological changes usually associated with laryngeal diseases; for there was neither lymph, nor pus, nor ulcer, nor vegetation, nor thickening of the mucous membrane in any part of its extent; but on closely examining its muscles I found the left crico-arytenoideus posticus muscle, pale and flabby and wasted, whilst the corresponding muscle on the right side was red and plump and healthy.

The enlarged glands had compressed or otherwise injured the left recurrent nerve, and also its parent, the pneumogastric nerve, and the left crico-arytenoideus posticus muscle, having been thus imperfectly supplied with nervous influence, had wasted.

If physiologists be correct in believing that in health the rima glottidis is enlarged during inspiration, and that the crico-arytenoidei postici muscles are the agents chiefly concerned in producing this enlargement, the "sonorous inspirations," which formed so prominent a symptom in this boy's case, may be explained by the atrophy which one of those muscles had undergone. In its atrophied condition the left crico-arytenoideus posticus muscle was unable to contribute its due proportion of motive power, therefore during inspiration the left arytenoid cartilage was moved less freely than the right, and of course an irregular and unequal dilatation of the rima, quite sufficient to account for the sonorous inspirations, was the result. The voice having remained to the very end so little impaired, affords a proof (if, indeed, a proof were wanted), that the crico-arytenoidei postici muscles are little concerned in phonation.

It is a curious circumstance in the history of this case, that the other laryngeal muscles known to be supplied by the recurrent nerve did not exhibit the same atrophied appearance as the crico-arytenoideus posticus. Had the boy survived, the glandular disease would probably in process of time have more completely disorganized the recurrent nerve or its parent, and then doubtless all the muscles supplied by the recurrent would have suffered in their turn.

In the August number of the *Dublin Journal of Medical Science*, for the year 1851, my friend Dr. Banks has published a case of extraordinary interest, in which the pressure of an aortic aneurism upon the left pneumogastric, had produced extreme atrophy of all the laryngeal muscles supplied by the left recurrent. "The lateral crico-arytenoid, and the thyro-arytenoid, had disappeared on that side; the contrast between the right and left posterior crico-arytenoid was very striking; the former was a well developed and bright red coloured muscle, while the left had degenerated almost entirely into a pale cellular structure,

having little appearance of muscle left. The oblique fibres of the arytenoid muscle seemed also, to have undergone a similar degeneration."

The mischief to the muscles of the larynx here described by Dr. Banks as having been the result of pressure exercised on the pneumogastric nerve, was precisely similar in kind although greater in extent than that disclosed by the dissection of the larynx of the boy Traynor. In Dr. Banks' patient all the laryngeal muscles supplied by the left recurrent nerve were wasted, in mine, the crico-arytenoideus posticus alone had suffered. In my case it was a dilator muscle which was in fault; in Dr. Banks' case the constrictors had suffered as well. In my case the inspirations were sonorous (snoring) so to speak, but the voice was unaffected; in Dr. Banks' case there was a remarkable "laryngeal blowing or roaring," but there was aphonia besides. Taken together the two cases afford interesting contributions to the pathology of the recurrent.

We can have but little difficulty I conceive, in assigning their proper causes to many of the other signs and symptoms which in my case the boy exhibited. The dull percussion sound yielded by a portion of the sternum and the adjacent part of the chest; the tubular breathing heard so distinctly in the same locality, the feeble respiratory murmur heard elsewhere over both the lungs, the imperfect dilatation of the lungs during inspiration, and the consequent inversion of the lower ribs during the same part of the respiratory process, are all accounted for by the enlarged glands within the chest, by the pressure exercised by those enlarged glands on the air passages, and by the spasm which was no doubt from time to time superadded. The distention of the tributaries of the superior cava, and the occasional dysphagia, depended so obviously upon the same causes that they require no special explanation.

LECTURES ON DISEASES OF THE STOMACH.

By D. B. LEES,

Physician to the Meath Hospital, Lecturer on Practice of Medicine.

DYSPEPSIA.

DIAGNOSIS; TREATMENT—DIETETIC, MEDICINAL.

The *differential diagnosis* of dyspepsia is sometimes very difficult; that is, to determine whether it is merely a functional affection, or symptomatic of some disease of the liver or stomach, especially cancer or chronic ulcer; but the history of the case, the aspect of the patient, the unaccountable changes in the digestibility of the same kind of food at different times, and the absence of the signs of organic disease, which I have already enumerated when speaking of those diseases, will, in most cases, prevent your making a mistake. The treatment is various, as it depends on the ex-

citing cause, for many, and even opposite conditions of the stomach may give rise to it; but as time will not allow me to enter more at large into this subject, or to consider the various forms and degrees of dyspepsia, I must content myself with giving you some general principles, which will be of use against the more ordinary forms of that troublesome affection, and refer you for a full description to the valuable article on "Indigestion" by the late Dr. Todd, of Brighton, published in the *Cyclopædia of Practical Medicine*. The first indication should be, to remove or correct the causes which have induced the disorder. These I have already alluded to; but as errors of diet are the chief physical causes of indigestion, there are a few obvious but very important rules (laid down by Dr. Abercrombie) which you ought always to bear in mind. He is of opinion, that in the regulation of food, much more depends on the quantity than the quality of the food; and he advises, 1st, "To restrict the food to such a quantity as the stomach shall be found capable of digesting in a healthy manner." 2nd, "To avoid indigestible articles of food, the mixing various articles which are of different degrees of solubility, and to masticate the food carefully." 3rd, "Not to take in additional food until time has been given for the solution of the former." It is sometimes difficult to get patients to submit to these rules, as they often find themselves getting thinner and weaker; and thinking it is from want of sufficient food, they wish for tonics and stimulants to rouse their appetite, and eat more food than they can digest. Dr. James Johnson (a great sufferer himself from dyspepsia) has laid down this very good rule to guide us:—"Any discomfort of body, any irritability or despondency of mind, succeeding food and drink, at the distance of an hour, or even a day, may be regarded (other evident causes being absent) as presumptive proof that the quantity has been too much, or the quality injurious." He recommends, in cases where a high degree of morbid sensibility prevails, farinaceous food as the least irritating to commence with; and advises four ounces of thick gruel, sago, or arrowroot to be taken three times a day, with intervals of six hours between; then to try beef-tea, with well-toasted bread; and then gradually to bring the stomach to digest some plain and tender animal food, as chicken or mutton; and according as the digestion improves, some well-boiled vegetable—such as cauliflower or a mealy potato—may be tried; their effects, however, should be watched with great care, as all vegetable substances are apt to ferment and turn acid; but well-boiled rice, with the gravy of roasted meat, makes a very palatable and wholesome substitute for them. Bread is a good article of diet, as it contains all the material requisite for nutrition, and is well suited to weak digestive powers; but it should be used stale, and in moderation, as, if it be eaten too fresh, or in greater quantity than the stomach can digest, it

will ferment, and cause acidity or heartburn. Good fresh cow's-milk is usually easily digested; but if heavy for the stomach it may be mixed with soda-water, seltzer, or lime-water; and it will sometimes agree when constituting the sole diet (milk diet), though it could not be borne as part of a mixed diet; or it may be given in the shape of curd loosely coagulated by rennet, and is very palatable mixed with white sugar, and (if the stomach can bear it) cream or sound white wine and nutmeg. Professor Oppolzer, of Vienna, prefers sour milk to sweet milk, because in it the casein is finely divided, and consequently more easily digested. Dr. Wood, of Philadelphia, recommends (in some cases) small quantities of sweet cream, and also ice-cream; but it should be allowed to dissolve perfectly in the mouth before being swallowed; he also allows good fresh butter, but condemns its use in dyspepsia, "if it has been subject to any culinary process, as heat has a very injurious effect upon it." Soft-boiled eggs, or the yolk of eggs beat up raw with water, or with wine, or brandy, or whiskey, may be sometimes allowed; but, as a general rule, custards are bad for dyspeptics. Chicken or turkey, tender mutton or beef, are the most digestible articles of animal food to commence with, and they are better roasted than boiled; but the skin, fat, and tendinous parts should not be eaten. The dyspeptic should avoid ducks, geese, salted or cured meats, soups, gravies, twice-dressed meat; also veal, pork, or the flesh of very young or of old animals, as it is less digestible than that of the prime of life; and you should be aware that the flesh of wild animals is generally more easily digested than that of tame. Fish, especially shell-fish (except oysters) should be avoided; also pastry, and all raw, or pickled, or flatulent vegetables, acid or preserved fruits. Fluids should be taken at all times in small quantities, and always after meals. Good spring water is the best general drink for dinner, but if a stimulant be required, you may allow the addition of some white wine which is free from acidity, as sound old sherry, or Manzanilla,* Marsalla, or Arinto, which are cheaper, but good wines. Claret will often agree with dyspeptic persons, and so will some of the other light French and Rhenish wines. A little brandy or whiskey may be taken in cold water, but punch or malt liquors must be forbidden. As a general rule, three meals a day may be allowed, with proper intervals between them, and they ought to be taken (if possible) in cheerful company; but the patient ought never to indulge in a hearty meal or in late suppers; nor should he eat if much fatigued or hurried, as he ought to take his food slowly, and masticate it carefully; in fact, he should be cautious not to

* This is not a very palatable wine (though it has lately been much recommended), and I have been informed that the natives of that part of Spain, who make much use of it, are very subject to nervous affections, especially tremors of the limbs.

overload his stomach, and ought to dine off one dish, as the least deviation from strict rules of diet may induce a relapse of all his sufferings. Stale bread and milk or cocoa (if they agree) is the best breakfast; but in most cases you may allow black tea, not very strong, or even coffee, with bread and butter; and some dyspeptics breakfast best on a chop or cold meat and a glass of water. A light tea, bread and milk, or a cup of gruel, sago, or some such farinaceous food, either plain or with a teaspoonful of brandy, may constitute the third meal; but remember that these rules of diet are not absolute; for though one patient may require to be kept on a rigid farinaceous diet, another may improve under animal food and stimulants.

Exercise is an important item in the treatment of dyspepsia, but ought to be taken cautiously at first, so as not to over-fatigue the patient, and ought always to precede meals. Walking, riding or driving, and boating, are the best forms of outdoor exercise; while in bad weather, or for those who are confined to the house, gymnastics and the various popular games may be substituted for them; but after a time more active exercise should be taken, as field sports, cricket and other such games, walking up mountains; and recommend the study of botany, as it engages the mind, and acts as a stimulus to outdoor exercise, particularly with females. Dyspeptic patients should give up the use of strong tea or coffee, tobacco in any form, and all habits that tend to enervate the body or mind—all sensual excesses or slothful indulgences; they should sleep on a mattress, in a large and dry well ventilated chamber, in the upper part of the house; should go to bed early, and not remain there for longer than six or eight hours; but if there is restlessness and a feverish state at night, with want of sleep, a tepid bath before going to bed will often afford much relief. They should sponge themselves with tepid or cold water every morning, and rub the skin with a coarse towel; a shower bath will also be of much use; but they should relax their mind from study or business, and if possible go off to travel and amuse themselves. As to medicinal treatment, be cautious and sparing of medicines at first, for there is often much harm done by making the patient swallow a quantity of physic when his stomach can scarcely digest the lightest food. The chief indications are, first to correct the secretions, and improve the morbid condition of the stomach; second, to regulate the bowels; and thirdly, to stimulate the stomach to perform its functions in an efficient manner. In some cases it will be good practice to commence the treatment with an emetic of ipecacuanha; but if there is congestion of the liver, a defective biliary secretion, with scanty secretion of high-coloured urine depositing lithates, you should commence by a mercurial purge; then give small doses of blue pill and rhubarb at night, followed by taraxacum, either plain or combined with senna, in the morning, and an occasional aloetic

purge, or an enema, so as to act on the large intestines. A certain class of medicines are usually recommended in all "stomach complaints," but you should be cautious in their use, as, if employed indiscriminately, or at an unseasonable time, they will do more harm than good; but if judiciously used, and combined with the rules of diet I have already laid down, they will be of the greatest utility. The principal remedies used in dyspepsia are, first, antacida, of which we have a goodly array in the preparations of soda, potash, ammonia, lime, and magnesia. The alkaline bicarbonates are generally preferable to the pure alkalies, and of these the salts of soda act more especially on the liver, increasing the secretion of bile; while those of potash act on the kidneys; and the salts of ammonia determine to the skin, and are especially useful in many of the nervous affections attendant on indigestion. Dr. Prout recommended that alkalies (in small doses) should be taken from three to six hours after a meal, "in order to *neutralize acids already formed*, for they have no effect in *preventing acidity*;" "on the contrary, when taken in large doses, and at improper times, the effect of alkalies is to cause an absolute increase of acid; for when a large quantity of alkali is taken into an empty stomach, the immediate effect is, that the stomach, in endeavouring to resume its natural condition, throws out an additional quantity of acid to neutralize the redundant alkali." Some practitioners are much influenced in their prescribing of alkaline remedies by the condition of the urine; but this is often a fallacious guide, for Dr. Bence Jones has shown that when the stomach secretes a large quantity of muriatic acid, the urine passed soon after meals is often alkaline from a fixed alkali, and yet that passed at another time of the same day will be acid; "so that the prescription of acid or alkaline remedies must never be made to depend on the reaction of the urine passed at any one period of the day; for at one hour acids may appear to be indicated, and at another alkalies." Dyspepsia may often be cured by a very opposite line of treatment—namely, by acids; and of these the nitric has been greatly praised by Pemberton, and by Abercrombie, who says that "it is often found one of the best tonics, and one of the best correctors of acidity." The late Dr. Prout recommended nitric and muriatic acids, or nitro-muriatic acid, for the deranged state of the stomach that is met with in what he termed "the oxalic diathesis," and which is characterised by distressing flatulence and palpitation or irregular action of the heart, with intermission of the pulse, occurring some time after meals. Dr. Budd states that "these acids are also often useful to persons in whom digestion is habitually slow and feeble from a scanty secretion of gastric juice, and who have a sense of weight or oppression at the stomach after meals; and also in the indigestion (described by Pemberton) attended with excessive formation of lactic acid,

that occurs in weak and nervous persons, and when the stomach has been weakened and disordered by some distant source of irritation." The best way to give these acids is from three to four drops in a little cold water an hour before meals; but Dr. Prout advises "their effects to be watched, and when they begin to produce a deposition of the lithate of ammonia, or of lithic acid, their use must be suspended." A medical friend has informed me that he has derived great benefit from dilute sulphuric acid, in doses of twenty drops in water three times a day; and I have used the dilute phosphoric acid with much success, especially in cases of dyspepsia where the urine passed before meals was neutral, or very feebly acid. In using the mineral acids, you must take care not to injure the teeth, which is avoided by using a straw or glass tube to suck the acid up with, and rubbing some butter over the teeth previous to taking it; or washing the mouth immediately after with some aromatic spirit of ammonia in water. These acids all appear to act as tonics, but another acid much used in dyspepsia—namely, the hydrocyanic—acts as a sedative, especially in nervous persons, or those debilitated by disease, and its action is often improved by combining it with the bicarbonate of soda or potash, or with lime-water, particularly if there is much acidity of the stomach. This is a favourite combination of Dr. Bright's, and I have often prescribed it with much advantage.

ON THE PHYSIOLOGICAL RELATIONS OF ALBUMEN.

By DR. HAYDEN,

Professor of Anatomy and Physiology.

(Read before the British Association.)

The inquiry of which this paper contains the first part, was undertaken with the view of determining the relations which subsist between the albumen and other organic constituents of the blood. It was suggested by the apparently anomalous fact, that in various conditions of the animal body—sometimes of confirmed disease, occasionally of temporary derangement—one of the staminal principles of the blood is eliminated in large quantity by the excreting organs; and regarding these, as I conceive we must, not only as deparants of the system, but likewise as adjuvants of nutrition to the extent of removing from the body superfluous alimentary matter, from whatever cause present, we are warranted in concluding that the state of the economy in which this occurs is one of repletion, or oversupply as regards the principle eliminated and the actual requirements of the body for that particular principle. It is well known that the "elements of respiration" may be stored up in the body by a process of deposition in the form of fat, to meet the urgent demand involving a large expenditure of these elements, to which variations

of external temperature and other circumstances occasionally expose the animal. Not so, however, the plastic elements of nutrition: these are appropriated only as required for immediate use in the renovation of the tissues, and if from any cause one happens to be in excess in the blood, whether absolutely, as the immediate result of ingestion, or relatively by loss of some of the allied constituents, then a process which may be conveniently designated *elemental adjustment*, is set up, by which the principle in excess continues to be discharged from the system, till it attain the normal proportion relatively to the other staminal elements.

Many facts may be adduced in proof of this self-adjusting property in the blood. Kanpp asserts that the quantity of chloride of sodium excreted by the kidneys is usually in proportion to that ingested,—but when, after prolonged abstinence from this salt, a large quantity of it is taken, then the quantity excreted in the urine is less than that ingested. Andral says that the first effect of hæmorrhage on the constitution of the blood is manifested in a decrease of the corpuscles only, but if it be prolonged or repeated, the albumen and fibrin are found to have undergone a corresponding diminution, whilst, according to Becquerel and Rodier, the equilibrium is not restored through the blood drawn, in which the corpuscles and albumen observe a regular and equal ratio of decrease with each subsequent bleeding. Andral further states that some females suffer during pregnancy a loss of corpuscles to the amount of twenty-seven parts in a thousand of the blood, and become anæmic; we know that it is in such cases more especially albumen is found in the urine of pregnancy. An absolute or relative decrease of the fibrin, as in scurvy and plethora, will give rise to hæmorrhage, by which, in the words of Andral, "the equilibrium is spontaneously established between the fibrin and globules." Becquerel and Rodier analyzed the blood in fifteen cases of Bright's disease, and found a mean of 117.28 parts of corpuscles and 60.58 of albumen in a thousand; the decrease of albumen was greater in proportion to the length of time that had elapsed from the commencement of the disease. This has an obvious relation to the progressive diminution in the quantity of blood corpuscles, as evinced by the increasing palor of the patient. In thirteen cases of chronic Bright's disease, in which the blood was analyzed by the same pathologists, it yielded a mean of 108.8 parts of globules and 55.93 of albumen per thousand, whilst the fibrin increased to a mean of 4.37. The blood occasionally found in the urine in these advanced cases exhibits a marked alteration in the physical character of its corpuscles, which are serrated or broken up into a *detritus*.

In order to determine the value to be attached to the views here enunciated, I performed some experiments, the result of which I beg to offer to the Association. The experimental portion of the inquiry had a threefold object: 1st, To determine the effect produced on the composition of the urine by induc-

ing a relative or absolute increase of albumen in the blood. 2nd, The action of urea on the blood-corpuscles as exhibited by the microscope; and 3rd, The proportion of albumen contained in the serous effusion of renal and cardiac dropsy respectively.

The first-mentioned object I thought would be best accomplished by abstracting blood from living animals, the quantity to be such as to make a decided impression on the system, and determined by the absolute weight of the animal's body. It is obvious that the effect of a first bleeding of this kind on the constitution of the blood remaining in the body would be a decrease in the proportion of corpuscles, and a relative increase of the albumen. An absolute increase of albumen might be induced by bleeding an animal to a small amount, and then injecting into the vein an equal quantity of a solution of albumen, having the temperature and specific gravity of the serum of the blood. The contrivance adopted for collecting the urine was a wire-crib, placed on a concave zinc table, having an aperture conducting into a receiver fixed beneath; in this the animal was imprisoned till a sufficient quantity of urine was obtained for analysis, when it was liberated in order to take exercise till the next experiment. A rabbit, weighing $3\frac{1}{2}$ lbs. was fed on cabbage, milk, and water; the urine passed next day was feebly alkaline, specific gravity 1.020, and free of albumen. The animal was then bled to six drachms, and fed on fresh grass and warm milk. The urine examined the following day presented the same reaction and specific gravity as at first, but became distinctly opalescent on the application of heat and nitric acid. A dog of 18 lbs. weight was fed on milk and oatmeal stirabout; urine neutral; specific gravity 1.020; contained no albumen. The animal was bled to eight ounces, on the 18th August; on 19th the urine collected during the previous night was examined and found neutral, specific gravity 1.030, contained traces of albumen. Examined again on 20th, the urine was found alkaline—its specific gravity had fallen to 1.020, but still a trace of albumen. August 21st, specific gravity 1.022; albumen as on yesterday. The quantity of blood taken in these two experiments was determined by the estimate of Welker, according to which the total quantity in the body of an animal is equal to one-thirteenth of its weight.

With reference to the detection of albumen in fluids containing only a minute trace of this principle, the aid afforded by the microscope deserves to be noticed: if a drop of the suspected liquid, the opalescence of which is barely discernible under the ordinary tests, be placed on a slip of glass under the microscope, and a drop of nitric acid added, a cloud of minute vesicles will be observed to pass slowly over the field of view, and if the line of advance of this cloud be accurately marked, the suddenness with which the constituent vesicles start into view from an apparently structureless fluid, cannot fail to strike the observer. These minute bodies present a highly refractive margin with a

light centre, and an average diameter of 1-10000th part of an inch.

A young dog, weighing 12 lbs. 7 oz. was next subjected to experiment; the urine collected before operating was free of albumen and alkaline; specific gravity 1.005; blood was now drawn from the jugular vein, to the amount of 5 oz. and into the aperture in the vessel was injected half-an-ounce of fresh dilute ov-albumen having the temperature and density of blood serum; bread and warm milk were given as food and ravenously eaten. The following day it was found that no urine had been passed in the interim. August 27th, 4 oz. of urine were collected, neutral in reaction; of specific gravity 1.030, and highly albuminous, being almost gelatinized by heat and nitric acid. The albumen was coagulated and collected by filtration, next dried, pulverised, and deprived of impurities by ether and boiling water, subsequently dried and incinerated; the total quantity of pure albumen thus obtained was nine grains. In order to determine what proportion of this was due to the ov-albumen injected, and what, if any, to the ser-albumen discharged in consequence of the loss of blood sustained by the animal, I endeavoured to ascertain the amount of pure dried albumen yielded by half-an-ounce of the white of egg, and found it to be $7\frac{1}{2}$ grains. I had expected, and probably would have found, had the operative part of the experiment been in all respects successful, a balance in favour of the albumen excreted with the urine, as compared with the quantity contained in half-an-ounce of the white of egg; but unfortunately at the moment when the last portion of albumen was injected, and before a ligature could be applied to the open vessel, the dog struggled violently and caused a fresh loss of blood, with probably a more than proportionate loss of the albumen injected, as the bleeding occurred chiefly by regurgitation from the heart. Five ozs. of urine were obtained from this dog on the 28th August; specific gravity 1.010; feebly acid, but no trace of albumen.

With reference to the next subject of inquiry indicated at the outset, namely the visible effect of a strong solution of urea on the blood corpuscles, the result of my experiments was not as decisive as I had expected, yet it was sufficient to show that when exposed for a few hours to the influence of this agent in a concentrated form, the corpuscles undergo a considerable modification. They are much diminished in number, and those which have not disappeared are become tumid and spherical; the action, however, is by no means energetic.

The proportion of albumen contained in the different dropsical effusions next engaged my attention. I had reasoned thus, *a priori*. If albuminuria be the result of an effort of the blood to restore the equilibrium between its corpuscles and albumen, by ridding itself of a portion of the latter; if anasarca be a concomitant symptom of the same disease, and produced by the same cause, then we

may not unreasonably expect to find an excess of albumen in the serum effused. In order to determine this point, it became necessary to institute a comparison between the fluids of cardiac and renal dropsy. I have been so fortunate as to obtain a sufficient quantity for examination from two patients affected with chronic Bright's disease, but failed in the short time allowed me to procure any from a case of cardiac dropsy.

This is the less to be regretted, since Andral's data are amply sufficient for our own purpose with reference to the latter disease, although as regards the former he has not supplied us with any information bearing on the point now under discussion, Andral analysed the serous effusion in sixteen cases of cardiac dropsy, and found a proportion of albumen ranging between four and forty-eight parts in a thousand. The facts elicited by myself from the two analyses I have made, do not, I am bound to say, support the hypothesis with which I started, namely, that the percentage of albumen would be found higher in the fluid of renal than in that of cardiac dropsy. In the first case examined, the proportion was twelve, and in the second twenty-four parts in a thousand. It will be observed that the higher of these two numbers stands midway between the minimum and maximum of Andral.

I now venture to submit in the form of propositions, the inferences which I think may be drawn with at least the force of probability from the preceding data. The inherent property of *quantitative adjustment* in the blood, probably has reference mainly to nutrition, which would appear to require as an essential condition for its healthy exercise, certain fixed mutual proportions between the constituent elements of the blood, but in part also to the maintenance of the normal relative density between its serum and corpuscles. The appearance of albumen in the urine is either transitory or persistent; when transitory it is produced either by an error of excess in the use of protein substances of which the blood seeks to relieve itself through the kidneys, or by a state of congestion of these organs in which the blood serum transudes through the walls of the renal capillaries and is discharged with the urine. When persistent it is probably always the result of loss or solution of the blood corpuscles, and produced by an inherent self-regulating property in the blood, by which the normal proportion between its constituent elements is sought to be re-established. In acute renal dropsy, the *point de depart* in the blood changes would appear to be loss of albumen; but in the chronic form of the disease, attended with uræmia, the starting point probably is solution of the corpuscles. The loss of albumen experienced by the blood in Bright's disease, would appear to be inversely proportioned to the degree in which it appears in the urine, and it may be in the dropsical effusion likewise. The quantity of fibrine in the blood is regulated in great part by that of the corpuscles, not by adjustment, but in virtue of the causal re-

lation subsisting between the disintegration of the one and the formation of the other. Diminution, therefore, of the quantity of globules in the blood will not necessarily cause elimination of the fibrin, because it involves diminished production of the latter; but the converse of the proposition will not hold, as diminished proportion of fibrin, by whatever cause produced, may give rise to elimination of the blood corpuscles in the form of hæmorrhage.

REPORT OF CASES IN HOSPITAL PRACTICE.

By Dr. JAMISON,

Surgeon to the Newtownards Infirmary.

TO THE EDITOR OF THE DUBLIN HOSPITAL GAZETTE.

Newtownards, 12th September, 1857.

SIR,—The following cases, and remarks on remedies, taken from the "Record of Sickness and Mortality" of 1856, of the Newtownards Workhouse Hospitals, may, perhaps, prove of some interest to your readers. I have not had so many cases to choose from as in 1855. In that year I treated 1,490 cases in the workhouse hospitals; of these, 110 were cases of cholera. In 1856 the number treated fell to 860—no inconsiderable number, however. By the way, can you account for the curious fact, that the Poor Law Commissioners, who adjust salaries, require no returns of the numbers of sick treated in workhouse hospitals?

I am your obedient servant,

D. JAMISON, M.D.

Phlegmasia Dolens.

Margaret Stewart, aged 28, admitted 29th January, 1856, in labour of her second child. About a year before this date she had been a considerable time in hospital, ill of dysentery, and narrowly escaped death. During her pregnancy nothing unusual occurred to her; her feet and legs swelled a little for a month or so before her confinement. Her labour was natural, and the child a tolerably stout female. No flooding occurred. About a week after her labour she began to complain of a severe pain in the middle of her right thigh (the œdema of the limbs had disappeared), and soon after the calf of the leg swelled, and then the entire leg and thigh. The usual appearances of *phlegmasia dolens* were well marked. The lochia were not suppressed; there was no tenderness to be felt about the pelvis.

I did not think this patient could bear any form of depletion. There never seemed to be any very acute inflammation. The heat in the limbs was never much increased, nor was the tenderness on pressure great, nor did the general fever seem to run very high. She was weak, and her constitution impaired. The treatment consisted in warm fomentations to the limbs first; then bandages, and

friction with warm oil; and one or two blisters. Full diet was given, and sulphate of quinine, and afterwards hydriodate of potass. She was discharged cured on the 9th April. The child died, some time after, of syphilitic cachexia.

This case is remarkable as a specimen of *phlegmasia dolens* arising from inflammation of the absorbents, and not having direct connexion with any form of phlebitis. I had under my care at the same time two other patients with phlegmasia dolens of the arm, one affected with cancer of the breast of the same side; in the other there exists a chronic painless swelling of the right arm, of some years' standing, it followed an ordinary mammary abscess of the same side; three or four times an erysipelatous inflammation, not extending below the surface, has attacked this arm; on these occasions the hand swells, but in general it is free from swelling; the arm is about three times the size of the other; the skin is free from disease, and the patient uses the arm quite freely.

Prolapsus of the Funis.

Margaret Burns, aged 29, admitted 29th July, 1856, in labour. Nothing unusual was noticed by the nurse, until after the membranes ruptured, when she found the funis prolapsed, and she then sent for me immediately. I found the circulation in the cord stopped, the os uteri well dilated, and the head within reach of the short forceps, which was applied, and the patient delivered. The child did not breathe for a considerable time, but ultimately it was restored by the usual means, without having recourse to Dr. Marshall Hall's ready method, by which, however, I have succeeded in restoring life, in almost hopeless cases of suspended animation.

Compound Fracture of the Skull.

Michael Boyd, aged 60, admitted to the hospital 4th September, 1856. Early on that morning he had been struck by a boy with a large room-brush, over the upper part of the left parietal bone; he was felled by the blow, and had his nose split the whole length, and his brow cut by the fall. There was considerable swelling about the wound on the parietal bone, and the probe indicated a depressed triangular fracture; but its exact nature was not ascertained until the swelling had partially subsided; it was then found that the depressed portion of bone was drawn down under the cranium anteriorly, and that a tuft of hair was driven into the skull, and retained firmly between the edges of the fractured bone. The depression would have held about half the thumb, and resembled in shape the end of the brush with which the wound was inflicted; now, when healed, it holds the top phalanx of the forefinger easily.

The patient was confined to bed, and kept on low diet; the wound was kept cold with wet lint, and calomel and antimonial powder was given for

seven or eight days. After several days one or two spiculae of bone were removed from the wound, after which more than a teaspoonful of broken-up brain was found one morning on the dressing, and a little more on one or two other occasions. The wound healed rather slowly, leaving the depression of the fracture very distinct. No bad symptom occurred while he was in hospital. He required confinement to bed only for one week, and he was eventually discharged, cured, on the 25th October, and has remained free from any head symptoms since.

Compound Fracture of the Leg.

William Spence, aged 28, was admitted into hospital 30th September, 1856. He had been thatching a corn-stack, and coming off it he fell, and his leg caught between the steps of the ladder, and broke. The foot and lower part of the leg were at a right angle with the limb, and an inch and a half of the fibula above the ankle-joint was extruded. I was obliged to enlarge the wound to return the bone. The leg was at first put up in straight splints, and the fracture of the tibia being transverse, it was easily kept in position. The wound, of course, did not heal by the first intention, and a profuse discharge was set up from both sides of the fracture. Various splints were used in this case, but the old fracture box, with a number of little cushions of curled hair along the sides, and one large one below, was found to suit best. When the state of the parts permitted, a small straight splint was added along the inner side of the leg. He was discharged, with the wound healed and the fracture united, nine weeks from the time of the accident. No shortening or deformity had occurred, but of course he was not able to walk well on the leg for several months after his discharge.

Amputation of Leg.

Marey Kelley, aged 36, was admitted into hospital 16th October, 1856. She was ill with hæmorrhæa, chronic cough, with muco-purulent expectoration, and general debility. She had had dropsy about ten years before. The left ankle-joint was greatly enlarged, and a number of abscesses discharging profusely, surrounded it. It had been two years slowly acquiring this diseased state. Her condition was partly the result of insufficient food and clothing. She was ordered full diet and wine, and her general health was greatly improved, and her strength in some degree restored; but as no improvement could be expected from the ankle-joint, she was induced to have it removed, which was accordingly effected on the 30th of October, without any remarkable incident being observed, except unusual softness and vascularity of the tibia. Her general health improved every day after, and she was discharged cured on the 24th December, and has remained well since.

Coma from Fright.

David Anderson, aged eight years, was admitted 29th November, 1856. He was insensible on admission, and remained so from Thursday night to Tuesday morning. After his recovery it was ascertained that he had risen in the night to go to the night-chair, and on seeing some white object, he thought it a "ghost," gave a scream, and dropped insensible. When brought to the hospital he was in a state of total insensibility; all power was completely lost, both of sensation and motion; he could not be made to feel; his limbs were relaxed and cold, as indeed was the entire surface of his body. There was no stertor; his pupils were dilated and sluggish; he passed his evacuations unconsciously; his pulse was exceedingly weak, and he could not swallow.

I injected warm milk, &c., twice a day into his stomach, had his head shaved and blistered; blisters were also applied to the calves of his legs, and turpentine enemata were administered. His consciousness very slowly returned, and several days elapsed before he could swallow; and for a long time he was stupid and lethargic, and could not either speak or recognise individuals. The blisters were dressed with mercurial ointment, and calomel given until his gums were slightly touched; after that he gradually recovered, and was discharged cured on 29th December.

(To be continued.)

CASE OF CHRONIC ABSCESS TREATED BY "DRAINAGE," WITH REMARKS.

By CHRISTOPHER FLEMING, M.D., M.R.I.A.
Surgeon to the Richmond Hospital.

The peculiarity of treatment adopted, and its satisfactory result, entitle the following case to more than a passing notice.

Michael Kelly, an indoor servant, aged 42 years, was admitted into hospital in the latter end of August last. He was of medium stature, and in medium condition, and applied with a large tumor occupying the left lumbar region. This tumor had grown up within the previous three months; had commenced, according to his account, like a common boil under the skin, and had reached its present magnitude without any amount of pain worth noticing. His general health was good; and he sought relief rather in consequence of the inconvenient bulk of the tumor, than from any absolute suffering. His varied occupations, as an ordinary indoor servant, were gone through without inconvenience; his appetite and his strength were unimpaired, and his whole aspect indicated a fair state of health. The diagnosis of the tumor, as a chronic abscess, was not difficult, and it was assumed from the history of its growth and progress, that it was most probably unconnected with any lesion of the spine, and that it was in a great

measure limited to the special region it occupied. By no manipulation could any abnormal fulness be detected in the course of the psoas or iliac muscles, neither was there any evidence of spinal disease. The abscess projected considerably backwards, in somewhat of a globular form, being rendered still more prominent and more tense when the trunk was flexed forwards, whilst occupying the space between the last rib and the crest of the ileum, over which it (as if) folded, and extending transversely for about five inches, the circumference of its base around measured not less than fifteen. The super-incumbent integuments were perfectly healthy, and moved loosely over it. Although I had repeatedly witnessed the removal of abscesses of similar character and size, through the medium of external applications, combined with the usual internal treatment, I yet decided to have recourse, in this case, to tapping by recurrent punctures with a trocar, when I read in some one of the periodicals a notice of Chassaignac's treatment of such abscesses. Through the kindness of Mr. O'Doherty, one of the surgeons to St. Vincent's Hospital, who had just procured from Paris the special instrument for the purpose, I was enabled to test this practice, and with his approbation and assistance I adopted it. On the 10th of September I transfixed, in a crucial form, at its base, the abscess, substituting the peculiar gutta percha tubing used, and securing it as directed. In the after management I followed the rules suggested, and although the man is as yet in hospital, and cure cannot be said to be fully completed, yet every favourable termination is to be anticipated, and no untoward symptom occurred to contraindicate the adoption of a similar proceeding in a similar case. The curative process was truly a process by perpetual "drainage" throughout; after a few days both patient and nurse understood its details, and little or no inconvenience attended its management. Ten days subsequently I removed one tube, and at the interval of ten more I removed the second; the tumor from day to day has flattened down, and now a solidified base remains, which it is reasonable to expect will gradually subside into a perfect consolidation of the original walls of the abscess. An occasional accumulation of matter takes place along the course of the tube-tracts, but these, it is to be expected, will not interfere with the ultimate cure. Throughout this plan of treatment I could not say there was any appreciable constitutional disturbance, and any attendant suffering was comparatively slight. Ordinary poulticing, with gentle compression, and attention to cleanliness, were the principal local means adopted; the general, had for their object the improvement of the health.

REMARKS.

Advocate, as each surgeon may, his favorite mode of treatment of chronic abscess, he must ad-

mit that disappointment too often baffles it, and that very unsatisfactory, if not ultimately fatal, results ensue, distinctly traceable to his operative interference. The reported success of the treatment specified in the above case, induced me to adopt it, as the data upon which it was based appeared to be rational. Not having had an opportunity of reading any remarks by its author respecting its advantages in abscesses at large, I hesitate on the present occasion to do more than note it in connexion with chronic abscess, being extremely sceptical as to its necessity or expediency in the "acute." For the "chronic abscess," where the opening of such is deemed prudent, the instrument recommended appears to be very efficient. By its provision the surgeon can use its trocar-portion as an explorer, and so, carefully direct his points for puncture. The length of the instrument, reaching with the handle to twelve inches or so, enables him to wield it with considerable ease, and fit it for the large chronic abscess, and by the canula-portion the accurate adjustment of a perpetual "drainage," is provided by means of the ingenious adaptation of a material whereby a continuous escape of fetid air and pus is, or rather can be, secured and little irritation produced.

Simple as this operative procedure of Chassaignac appears, to be efficiently as well as neatly and cleanly executed, it requires for its puncturing stage a well-selected position of surgeon and patient, and I might say a sudden and firm "stiletto" movement of hand, and for its tubing stage, proper fitting of such tube, and proper adjustment of it to the canula should be arranged beforehand. In the after treatment care must be taken that the tubes or the perforations in them are not blocked up; at their points of entrance and exit, they are firmly girted by the integuments, but the slightest separate traction of the extreme ends of each secures their patency. Other remarks, to be strictly clinical, would at present be premature. Imperfect as the few I make are, however, I am somewhat reconciled to them from the reflection that Mr. O'Doherty is at present directing his attention to the subject, and that the opportunity afforded him in his present position of investigating it practically, combined with that heretofore enjoyed in Chassaignac's "Clinique," must tend to compensate for my omissions.

EPIDEMIC CHOLERA.

If past experience is to be trusted as a lesson for the future, we cannot fail to learn that we are threatened with another invasion of cholera; and that it will arrive, as it did on both its former attacks, from Hamburg. Between the 29th of August and the 6th of September there were 289 cases, of which 186 proved fatal. We have not received later accounts of the exact number of cases and deaths, but we have been informed that the mortality has been very large. Dr. Webster, in his late northern tour, followed in the track of the pestilence from Königsberg westward. He describes the severity of the epidemic as extreme. At Upsala

the university had been closed and many of the inhabitants had fled.—(*Medical Times and Gazette*.) The General Board of Health, Whitehall, has issued a precautionary address to local Boards of Health on this subject, commencing thus:—"Cholera has again become epidemic in several of the Baltic ports and at Hamburg. On each of the three former occasions when the disease has visited England, its first appearance in our eastern ports followed closely on its epidemic outbreak in the last named city. During the past three months there has been observed in London and in some other parts of England, a very unusual fatality from diarrhoea; and this derangement of the public health is such as on the previous occasions referred to, preceded the commencement of the epidemic periods of cholera. The General Board of Health deem it expedient to call the attention of local Boards of Health to these facts, and most earnestly recommends that the powers vested in such boards for the protection of the public health be exercised for the present time with especial vigilance." Advice to the local Board of health with reference to epidemic cholera, is then given at considerable length, and the powers vested in such board by Acts of Parliament, are fully defined.

Selections from British & Foreign Journals.

SALIVARY CALCULUS.

A soldier, *æt.* 24, was admitted into hospital on the 14th April, 1857, labouring under symptoms of glossitis. The tongue was swollen to more than double its natural size; the point of the organ stood out between the teeth, and was quite rounded, as were also the edges; it was very painful, and intensely red. The chewing of hard food was impossible, the difficulty of swallowing great, speech unintelligible, and the jaw could not be brought together. The secretion of saliva was somewhat augmented. In the left sub-maxillary region could be felt many enlarged glands; the sensibility here, too, was great, and firm pressure caused severe pain. On the floor of the mouth, behind the left caruncula sublingualis, a roundish swelling could be felt; it was about the size of a walnut, moderately hard, but not elastic. From the left trigonum inframaxillare this could not be felt, owing to the general swelling. The acute symptoms had lasted five days.

The extreme infrequency of salivary calculus of the ductus whartonianus rendered the diagnosis difficult and obscure. Portions of ice were taken in the mouth, and cold applications used externally, and a restricted diet enjoined. On the fourth day, by this treatment, the general swelling had almost disappeared. On the following afternoon, after having chewed a piece of bread he produced a salivary calculus which he had dislodged with his finger.

The cavity was examined with a fine sound, and a narrow canal was discovered, which extended outwards and backwards, and was about three lines deep; it was therefore evident that the body was a salivary calculus. It was six lines in length, and four in diameter. The colour of the stone was white, the surface rough and uneven, the fracture scaly. The chemical analysis showed that the principal ingredient was the ammonio-magnesian phosphate; there was also some phosphate of lime. The patient felt himself relieved after the separation of the calculus, all the inflammatory symptoms having soon subsided.—*Dr. Heinrich*—"Zeitschrift der k. k. Gesellschaft der Aerzte zu Wien."

NOMA AFTER TYPHUS.

At a recent meeting of the Imperial Association of Physicians at Vienna, Dr. Salzer brought under the

notice of the society a person who by noma following typhus, had lost the soft parts of the entire left cheek, a part of the upper and lower lip, and the left nostril. It was proposed to supply this enormous loss of substance by a series of plastic operations.

ON SOME OF THE USEFUL APPLICATIONS OF THE PERMANGANATE OF POTASH.

By G. F. GIRDWOOD, M.D.

I had lately a distressing case of *cancer of the os uteri* under treatment: the pain was often agonising, and the discharge so offensive as to add bitterly to the sufferings of my patient, who possessed a keen sensibility. It was a case in which I felt the want of some deodorant and escharotic combined, and was induced to try the permanganate of potash. I employed it as a lotion (twenty grains to the pint) injected frequently during the day, and was much pleased with the comfort given to the patient by it.

I was next induced to try it in the case of a naval officer of rank, afflicted with *cancer of the breast*. Here also the application has been most serviceable. Its application as a powder, sprinkled on the sloughy mass, or as a lotion (ten grains to the ounce) to the surface of the wound, has not been attended with pain. From a gaping sore, in most offensive condition, it has occasioned the wound to assume, in some parts, a disposition to granulate. The odour of the apartment previous to the employment of the permanganate was so offensive as seriously to compromise the comfort of the family. This inconvenience is entirely removed.

I was consulted, in the spring, respecting a most unhealthy *eroding ulcer on the thigh*. It was one of those foul ulcers met with in constitutions broken down by syphilis or intemperance, and where the dyscrasia is so great as to baffle the ingenuity of the profession to restore a healthy action in the system. The permanganate was here applied as a lotion, and was most efficacious in removing the slough, cleansing the sore, and inducing healthy action.

An elderly female, long afflicted with *caries of the tibia*, which, from the offensive odour, prevented her performing the duties of her position in life with any comfort to those around her, has enjoyed perfect freedom from this annoyance ever since she has had recourse to the permanganate as an application to the leg.

[Dr. Girdwood then details cases of *scrofulo-syphilitic* and *constitutional indolent ulcers*, in which he used this drug with success, and adds:—]

The foregoing statement indicates the variety of cases in which the permanganate of potash may be applied. I have used the remedy generally as a lotion; but although I have not found it necessary, for the purposes I have generally required, to use it in a stronger form, I would recommend, when it is wished to destroy masses of cancerous growth, its use in the solid form, either as a powder, as I have done, or in a mass, as the sulphate of copper or other caustics. The lotion supersedes all the charcoal, yeast, and carrot poultices: let this simple solution—make it as weak as may be thought requisite to effect the object—two to twenty grains, or more if liked—be used on a piece of lint, instead of any of these applications. The permanganate of potash is more useful than any of the other compounds of manganese and potash as a caustic or deodorant. The permanganic acid contains more oxygen than the manganic. The permanganic acid has the composition MN_2O_7 , whilst the manganic acid has a composition MNO_2 .

As the escharotic action of these bodies, as well as their deodorant quality (a quality which has been long known to chemists), depends on the ease with which they part with the oxygen with which they abound, clearly that preparation which yields the larger quantity

of oxygen must be preferable: this is the permanganic acid as permanganate of potash.

As a *deodorant*, as an *escharotic*, as a *stimulant*, it is a most useful application, combining, as it does, all these three qualities; but as a quality still to be claimed in its favour is the ease of its exhibition as a lotion applied to, or in powder sprinkled on, the sore, or as an injection. To conclude, I may say, that whilst from the foregoing relation its advantages have been attempted to be illustrated, its use is also suggested in every sort of case where it is desirable to combine all the qualities this agent so beneficially possesses: in such cases, for instance, as old chronic ulcers, warty growths, syphilitic sores, as a caustic in the primary stage, or in gonorrhœa as a stimulant injection.

I have found it a most desirable deodorant. A teaspoonful of the substance powdered, added to a table-spoonful or two of water, just enough to moisten it well, and sufficient to cover the surface of a flat dish—a dinner-plate, for example, being used for the purpose—giving a broad surface for absorption, and this plate placed under the bed, or anywhere most convenient in the sick-chamber, all odour disappears; and it has an advantage above those in general use in the sick-chamber, that it has no odour of its own. Vinegar and chlorine and nitrous acid gas are often of themselves a nuisance; whilst destroying one odour they create another; but the permanganic acid has none. It only destroys; it does not create. I have employed the solution successfully in my stables, and in other places engendering odours. It does not require frequent change. Has it lost its original beautiful purple colour? Has it become black and slimy? If so renew it, but not till then.

The permanganate of potash was introduced some time ago as a remedy in diabetes, so that it is well known to chemists.—*Lancet*.

EXAMINATION FOR THE DEGREE OF M.D. IN THE QUEEN'S UNIVERSITY IN IRELAND.

September, 1857.

MEDICINE.—Examiner, J. C. FERGUSON, A.M., M.B.

1. What are the local complications met with in our typhus fevers; and what the stimulants most used in their treatment?
2. Describe the pathology of cerebral hæmorrhage through its different stages, and the principles of treatment applicable to each.
3. State the point of difference between the products of inflammation in mucous and serous membranes.
4. Enumerate all the causes of enlargement of the thoracic parietes, and the physical signs which attend and indicate each.
5. Under what circumstances is albumen found in the urine; and what importance should be attached to it in forming prognosis?
6. Describe the different stages in the development of tubercle in the lung, and the means of determining the presence of each.
7. What is the differential diagnosis of scarlatina and rubeola, founded on the complications and eruptions in each?
8. What are the leading indications and contra-indications to the use of mercury?

SURGERY.—Examiner, MAURICE HENRY COLLIS, M.B., F.R.C.S.I.

- A. 1. Point out the differences, local and constitutional, between *anthrax* and *furuncle*.
2. Mention the various ways of treating anthrax, with

the authorities for each, and the cases to which each is specially adapted.

3. What condition of urine has been said to be associated with anthrax; and by whom?

4. Under what circumstances is anthrax generally fatal?

B. 1. Enumerate the causes that give rise to periostitis.

2. How do the constitutional symptoms vary in the acute and chronic forms of the disease?

3. What bones, and what parts of bones, are most affected in rheumatic periostitis?

4. How would you treat simple acute periostitis, rheumatic periostitis, and syphilitic periostitis.

C. 1. Enumerate the causes that will produce retention of urine.

2. Specify, in their order, the various remedies you would adopt in retention from spasm.

3. What dangers are to be feared when there is retention, with lacerated urethra? and

4. How are these dangers to be met?

ANATOMY.—Examiner, ROBERT HARRISON, M.D.,
Professor of Anatomy, T.C.D.

1. Contrast a cervical, a dorsal, and a lumbar vertebra.

2. Describe the axis, or the second cervical vertebra.

3. Mention the boundaries of the spinal canal, and its form and size in the cervical, dorsal, lumbar, and sacral regions.

4. Mention the normal curvatures of the spinal column.

5. In what part of the spinal column is a lateral curvature usually observed; how has this curve been accounted for? When excessive, state the appearances; also the deviations from the natural form, in other parts of the body, caused thereby.

6. The muscles, and all other accessory parts, having been removed from the spine of a fully developed foetus and from that of an adult, contrast the two columns, and state accurately the differences between them, both in the general form and in the structure of the different segments.

7. Describe the form and aspect of the articular condyles of the inferior maxillary bone.

8. Describe the attachments, relations, and actions of the internal and external pterygoid muscles.

9. State the attachments of the buccinator muscle, and the nerves which endow it with motor power.

10. Describe the upper extremity of the femur; the head, neck and trochanters.

11. Describe the psoas magnus muscle, its attachments, its several relations, and its actions.

12. Describe the situation and relations of the pancreas, and the best mode of exposing it, *in situ*.

13. Describe the excretory duct of the pancreas, and the mode in which it opens into the duodenum.

14. Suppose the pancreas carefully removed, mention the several objects that come into view, and their relative positions.

15. Describe the course and relations of the subclavian artery in its third stage.

16. Mention the channels and the anastomoses whereby the circulation of the blood in the right arm can be maintained, after the obliteration of the innominate or brachio-cephalic artery.

17. Describe the course and distribution of the motor portion of the fifth pair of nerves.

18. Enumerate the several connections of the portio dura to other nerves in the cranial portion of its course.

19. What nerves supply the muscles of the soft palate and the uvula?

PHYSIOLOGY AND COMPARATIVE ANATOMY.—Examiner, ROBERT HARRISON, M.D., Professor of Anatomy, T.C.D.

1. Describe the process of ossification in a vertebra; that is, enumerate the principal ossific points, and the

epiphyses in each; the time and order of their appearance, and the periods of their completion.

2. Describe and contrast the form, position, and development of those processes of the vertebra, named "diapophyses" and "parapophyses," in the cervical, dorsal, and lumbar vertebra.

3. Enumerate and describe the vertebral segments of the cranium, as arranged and named by Owen.

4. In what bones does the process of ossification first commence?

5. Describe the process of ossification in the femur, the number of epiphyses, the time and order in which they appear, and in which they are completed.

6. State the supposed uses of the pancreatic secretion, especially that ascribed to it by C. Bernard.

7. The "pyloric appendages" in fish are considered as the analogue of the pancreas; why?

8. Mention the muscles which the portio dura supplies; also those which it does not supply.

9. In some cases of paralysis of the portio dura the four senses—sight, smell, hearing and taste, are more or less impaired, also the process of deglutition; state the several anatomical communications of this nerve which may, in some measure, explain these effects. In such cases, is the uvula ever affected, and how?

CHEMISTRY.—Examiner, THOS. H. ROWNEY, Ph.D.

1. Describe the preparation and properties of carbonate of magnesia.

2. Give the laws of combining proportions.

3. Describe the continuous process for obtaining the

4. Give the method of obtaining the hydrated peroxide of iron.

5. Describe the preparation and properties of calomel.

6. Give the properties and principal sources of carbonic acid.

7. Describe the preparation, properties, and uses of sulphurous acid.

8. How is ammonia obtained, and what are its properties?

9. Give the composition in symbols and systematic designation of calomel, corrosive sublimate, sugar of lead and Epsom salts.

10. Give the process for preparing valerianic acid.

11. What is meant by a homologous series of compounds?

12. How may uric acid be detected in urine?

13. Give the tests for phosphoric acid, hydrochloric acid, potash, lead, and arsenic.

14. What is the difference between a fat and a fatty acid; and how is the latter extracted from the former?

15. How is the protoxide of nitrogen prepared, and what are its properties?

MIDWIFERY AND DISEASES OF WOMEN AND CHILDREN.
Examiner, DR. HARVEY.

1. Describe the menstrual discharge, noticing specially its nature, composition, and changes of character. State the points of resemblance and of difference between it and the lochia. Define the extent of surface from which it is derived. How do you explain the occurrence of menstruation during pregnancy?

2. Describe the situation of the female urethra, and its relations to the neighbouring structures. How is the catheter best introduced; and how is the operation modified by conditions occurring during labour, and in retroversio uteri?

3. What is a Graafian vesicle? Of what structures does it consist? Enumerate its contents, and state how they differ in their relations to it, and to each other, in the immature and in the mature state of the vesicle.

4. Give an outline of the process by which the embryo comes to establish a connexion with the system of the mother; and mention those structures not found in the earlier states of the ovum, which are the result of that process.

5. At what period of gestation does abortion most frequently occur? How do you explain the circumstance? What precautions should be taken to guard against the occurrence at this time?

6. You are called to a lady, the subject of abortion, about the end of the fourth month of gestation. The fœtus has been expelled, the cord is broken, and the placenta and membranes remain in utero. No hæmorrhage or other bad symptom at present. What would be your treatment under such circumstances; and if it should not be successful, what would be your ulterior course?

7. What circumstances, during the labour or otherwise, would lead you to suspect the existence of twins? Detail the most important steps in the management of a labour with two children.

8. What is the rate of mortality of the child in footling cases, and how does the danger arise? Mention the various precautionary steps in the management of such a presentation best calculated to preserve the life of the child. If one foot only were presenting, would you bring down the other or not, and give the reason for your choice?

9. A lady, who is anxious to nurse her child, has engaged you to attend her in her first confinement. State how you would manage the breasts from the first, so as to secure a healthy and comfortable lactation.

10. Give the symptoms, pathology, and treatment of phlegmasia dolens.

11. State your views as to the mode in which ergot, given to the mother during labour, may cause the death of her child; and give your reasons.

12. Describe the progress of marasmus, its morbid anatomy, prognosis, and treatment.

MATERIA MEDICA AND PHARMACY.—Examiner, Dr. GEOEGEGAN, Prof., R.C.S.I.

1. Define the term cathartic, and state the ordinary classification of cathartic medicines, explaining the action of each class, and giving examples.

2. Enumerate the officinal *drastic* purgatives, and their respective doses; name the plants which furnish them, the part of the plant from which each is obtained, and the reputed active principle of each.

3. Describe the sensible and chief chemical characters of tartar-emetic, and write its composition in symbols.

4. How are potassa caustica, lunar caustic, and chloride of zinc respectively prepared, and what is the *modus operandi* of each as an escharotic?

5. Contrast the composition, physical and chemical properties, and doses, of calomel and corrosive sublimate, and name two analogous pharmaceutical compounds of mercury.

6. Name the preparations of opium and of morphia contained in the Dublin Pharmacopeia, and specify the quantity of the active ingredient in each.

7. What are the ordinary adulterations of sulphate of quina, scammony, iodine, opium, and iodide of potassium?

8. In what respective states of combination does the iron exist in the *mistura ferri aromatica*, *mistura ferri composita*, and the *ferri acetatis tinctura*?

9. Explain briefly the mode of preparing muriatic acid; describe its properties and its uses in pharmacy and surgery; and state the composition of the dilute acid of the Dublin Pharmacopeia.

10. Name the drugs (1 to 10) placed before you, and the chief physiological action of each.

Prescriptions.—Prescribe, in unabbreviated Latin, 10, an 8-oz. mixture, containing squill, digitalis, juniper, and acetate of potass, with full directions for use.

20. Antispasmodic pills, directing them to be silvered, and two to be taken at bed-time four times a week.

Translate the following:—Recipe.—Radici Gentianæ concisæ sequidrachmam, aquæ destillatæ ferventis ocariū, digere per horæ quadrantem in vase operculato

et cola, deinde adde tincturam ejusdem, sescunciam. Sumatur semuncia quotidie ante jentaculum.

MEDICAL JURISPRUDENCE.—Examiner, Dr. GEOEGEGAN, Prof., R.C.S.I.

1. Enumerate the symptoms which precede death by cold, and the usual *post-mortem* appearances; also state the conditions which favour and which retard the influence of that agent in causing death.

2. What are the chief indirect causes of death in cases of wounding, and at what respective periods do they in general come into operation?

3. State the means, medicinal or otherwise, by which criminal abortion is ordinarily attempted, and their several modes of action.

4. Within what respective intervals after ingestion, do poisonous doses of arsenious, sulphuric, and Prussic acids, corrosive sublimate, and tincture of opium, usually begin to manifest their general effects?

5. Describe the external conditions which have been observed in death by hanging, and state the combination of them most frequently noticed in practice.

6. How would you proceed to determine the existence of copper in the tissues, and what exception might be taken against its presence, as an indication of copper poisoning?

7. Describe the effects of exposure to the fumes of charcoal, and the treatment to be adopted in such an emergency.

8. What are the signs of recent delivery at the full period?

BOTANY.—Examiner, Professor W. SMITH, F.L.S.

1. Name the principal plant-tissues, in the order of their generality or importance; ascribe to each their peculiar functions; and give examples of special modifications.

2. Describe the peculiar functions of plant-life to which the direct action of light is essential.

3. Distinguish cryptogamous from phanerogamous plants by positive as well as negative characters; mention the principal classes and sub-classes of the former, with their diagnostic characters.

4. Give the botanical names of the plants yielding castor-oil, colchicith, scammony, colchicum, and Iceland moss; and refer each to its natural order.

ZOOLOGY.

1. Group the classes of the animal kingdom according to the typical modes in which they exhibit the respiratory process.

2. Distribute the class Pisces according to the arrangement of Agassiz; mention the diagnostic characters of each division; and give illustrative examples from the British Fauna.

3. Give the characters of the class Cephalopoda, and the names and characters of the orders into which it may be divided.

4. Describe the peculiarities of structure and function by which the cetacea are distinguished from true fishes, and in which they correspond with the other mammalia.

NATURAL PHILOSOPHY.—Examiner, JOHN STEVELLY, LL.D.

1. A farmer requires to carry a load of 140lbs. on a pole 12 feet long, but he wishes to load his son, who carries the other end of the pole, with only 40 lbs. of the entire weight; where must he place it on the pole?

2. Two weights, one of 112 lbs., the other of 80 lbs., are suspended from the extremities of a uniform rod, 7 feet asunder; the rod itself weighs 32 lbs.:

a. What point of the rod must be supported, in order that it may rest in any position in which it is placed?

b. What is the pressure sustained by the support?

3. A wheel of 5 feet in diameter is acted on by a force of 20 lbs. at its circumference; what load will this sustain on a compound axle, the diameter of one part of which is 16 inches, and that of the other part 14 inches?

4. A falling pulley has two sheaves in its block, to which one end of the rope which reeves it is attached; what weight, attached to the block, would a power of 168 lbs. drawing the other end of the rope sustain in equilibrio?

5. Two impulsive forces, one of which, if it acted alone, would impart to a certain body a velocity of 12 feet per second; the other, if it alone acted on the same body, would impart a velocity of 16 feet per second; if they act together on the body, in directions which contain a right angle, what velocity will the body begin to move with, and how is the direction of the motion determined?

6. How many decimal parts of an inch must I alter the length of a pendulum that loses two seconds in the twenty-four hours, to make it go right? (The correct length of the pendulum which swings seconds is, suppose, 39.1393 inches.)

7. The specific gravity of wrought iron 7.78. A ploughshare, let gently into a vessel of water, carefully filled up to an overflow pipe, is found to displace 114.5 cubic inches of the water; what is the weight of the ploughshare.

8. Explain the use of the parabolic reflector in a light-house.

9. Explain how the right ascension of a heavenly body is observed, and the rule by which the hours, minutes, and seconds shown by the clock, are converted into degrees, minutes and seconds.

10. In a certain hygrometric state of the air, 100 cubic inches are found to weigh 30.5 grains. Explain how the number expressing the specific of air in that state is obtained; distilled water at 60°, and standard pressure being taken as unity.

11. Explain how the height of a homogeneous atmosphere of the same constitution as in the preceding question may be calculated, the height of the barometer being supposed 30 inches, and the density of mercury 13.6 to distilled water, 1.

12. Explain the great accumulation of electricity obtained by charging a Leyden jar.

13. State, clearly, the difference of action of one permanent magnet when brought into the neighbourhood of another; and of the same magnet when brought near a bar of soft iron; and explain the difference.

14. A flask of water, when boiling freely, is corked up, and all ebullition immediately ceases. It is then plunged into cold water, when violent ebullition again commences. Explain these facts.

MODERN LANGUAGES.—EXAMINER, PROFESSOR DR VERICOUR.

To translate a given passage from French (*Dubois*) into English.

To translate a given passage from German (*Hufeland*) into English.

To translate a given passage from Italian (*Boccaccio*) into English.

To translate into French, German or Italian, a given passage from "*Medical Review*."

The Medical Degrees and Certificates conferred were:

Degree of M.D.—J. Colahan, Galway; J. W. Collins, M.R.C.S. Edinburgh, Cork; M. J. Crean, Galway; A. Dunlop, M.R.C.S. England, Belfast; P. J. Kelly, Galway; W. M'Cormac, A.B., M.R.C.S. England, Belfast; A. E. D. Mapother, L.R.C.S.I., Galway; J. M'Crevey, M.R.C.S. Edinburgh, Belfast; M. O'K. Morris, A.B., Cork; D. B. O'Flynn, A.M., Cork; D. M. O'Hara, Belfast.

Eleven gentlemen obtained the Certificate of the first Medical Examination.

The Medical Honors distributed were:—E. D. Mapother, M.D., £20 and gold medal, first prize in Medicine; W. M'Cormac, M.D., £10 and gold medal, second Medical Examination; A. Dunlop, M.D., £20, second prize in Medicine; J. MacCrea, £10, first Medical Examination.

In our next number we purpose giving the Examination for Honors.

APPOINTMENTS.

WAR OFFICE, PALL-MALL, OCTOBER 2.

7th Dragoon Guards—Surgeon William Arden, from the Military Train, to be Surgeon, vice Dolmage, appointed to the Military Train.

Military Train—Surgeon Gideon Dolmage, from the 7th Dragoon Guards, to be Surgeon, vice Arden, appointed to the 7th Dragoon Guards.

18th Foot—Assistant Surgeon Richard Armstrong Hyde, from the Staff, to be Assistant Surgeon, vice Phillip, who retires.

60th Foot—Staff Surgeon of the Second Class, John E. Mier Lewis, M.D., to be Surgeon.

Rifle Brigade—Staff Surgeon of the Second Class, James Edwin Scott, M.B., to be Surgeon.

2nd West India Regiment—Surgeon Deodatus William Ekin, from half-pay of the 60th Foot, to be Surgeon, vice Mostyn, appointed to the Staff.

HOSPITAL STAFF.

Surgeon John William Mostyn, M.D., from 2nd West India Regiment, to be Staff Surgeon of the Second Class, vice C. W. Pollock, whose restoration to full pay, as stated in the "*Gazette*" of the 28th ultimo, has been cancelled.

Assistant Surgeon Frederick Douglas, M.D., from the 28th Foot, to be Staff Surgeon of the Second Class, vice Lewis, appointed to the 60th Foot.

Assistant Surgeon Robert Macgregor, from the 29th Foot, to be Staff Surgeon of the Second Class, vice Scott, appointed to the Rifle Brigade.

Staff Assistant Surgeon Richard L. Butler has been permitted to resign his Commission.

WAR OFFICE, PALL-MALL, OCTOBER 9.

2nd West India Regiment—The appointment of Staff Assistant Surgeon E. J. Crane (Vice Clutterbuck, appointed to the Staff) on 28th September, has been cancelled.

HOSPITAL STAFF.

Deputy Inspector General of Hospitals, Thomas David Ross, M.D., from half pay to be Deputy Inspector General of Hospitals.

To be Assistant Surgeons to the Forces—Assistant Staff Surgeon Henry Titterton, M.D., from half pay, vice Thornhill, appointed to the 42nd Foot; William Samuel Chapman, Gent, vice Hooper, appointed to the 42nd Foot; Philip Brooke Smith, M.D., vice Carless, appointed to 72nd Foot; David Chambers McFall, Gent, vice McSheehy, appointed to the 1st Dragoon Guards; George Davidson Milne, M.D., vice Slaughter, appointed to the 7th Light Dragoons; Alexander Thornburn McGowan, M.D., vice Baker, appointed to 6th Foot; James Landale, M.D., vice Parr, appointed to the 56th Foot; William Silver Oliver M.D., vice Ffolliott, appointed to 66th Foot; Alexander Watt Beveridge, M.D., vice Jones, appointed to 7th Foot; John Henry Beath, M.D., vice Henry, appointed to 43rd Foot; William Ashton, M.B., vice Ramsay, appointed to the 27th Foot; William James Mulhan, Gent, vice Grant, appointed to the 56th Foot.

DEATH.

We regret to have to announce the death of Dr. O'BRIEN DE LINHAM, M.D. Ed., F.R.C.S.L., Chairman of the Court of Examiners, R.C.S.L., Surgeon to St. Vincent's Hospital.

COMMUNICATIONS have been received from Mr. O'Brien de Linham, Dr. Mapother, Dr. O'Donovan, Dr. Haughton, Dr. L. Beale, &c. &c.

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SCHOOL OF MEDICINE AND SURGERY.

UNIVERSITY PROFESSORS,

Regius Professor of Physic.—WILLIAM STOKES, M.D.
University Professor of Surgery.—J. W. CUSACK, M.D.

SCHOOL OF PHYSIC IN IRELAND.

Incorporated, 25 Geo. III., c. 42, & 40 Geo. III. c. 84.

**PROFESSORS ON THE UNIVERSITY FOUNDATION OF
TRINITY COLLEGE.**

Anatomy and Physiology.—ROBERT HARRISON, M.D.
Surgery.—ROBERT WILLIAM SMITH, M.D.
Chemistry.—JAMES APJOHN, M.D.
Botany.—WILLIAM HARVEY, M.D.

**THE KING'S PROFESSORS ON THE FOUNDATION OF
SIR PATRICK DUN.**

Institutes of Medicine.—ROBERT LAW, M.D.
Practice of Medicine.—JOHN BANKS, M.D.
Materia Medica.—JONATHAN OSBORNE, M.D.

**PROFESSORS OF THE KING AND QUEEN'S COLLEGE OF
PHYSICIANS.**

Midwifery.—FLEETWOOD CHURCHILL, M.D.
Medical Jurisprudence.—THOMAS BRADY, M.D.

MATRICULATION.

All Students in Medicine of the University of Dublin must be matriculated by the Senior Lecturer of Trinity College; but no such student shall be obliged to have his name on the books of said College, or to place himself under the tuition of one of the Tutors of the College; nor is such matriculated Student liable to any academical duties, unconnected with the School of Medicine and Surgery, unless he desire to obtain a degree in Medicine or a Diploma in Surgery.

Matriculated Students, who are not Graduates of the University in Arts or Medicine, are admissible to Examination for the Licence of the King and Queen's College of Physicians, but are not eligible to a Fellowship in that College, or to the Professorships on the University Foundation in the school of Physic.

A fee of five shillings is made payable by the Act 40 Geo. III. c. 84, s. 34., on the matriculation of each student.

DEGREES IN MEDICINE.

1. Bachelor in Medicine.

A Candidate for the degree of Bachelor of Medicine must be a Graduate in Arts, and may obtain the degree of Bachelor of Medicine at the same commencement as that at which he received his degree of B.A., or at any subsequent commencement, provided the requisite Medical Education shall have been completed.

The Testimonium of the M. B. degree will contain the following certificate :—

“Testamur A.B. sedulam operam medicinæ navasse, et examinationes coram professoribus feliciter sustinuisse.”

The Medical Education of a Bachelor of Medicine is of four years' duration, and comprises attendance on the following Courses of Lectures :

Courses of Six Months' Duration, or longer.

Anatomy and Physiology.—Every day.
Practical Anatomy, with Anatomical Demonstrations.—Every day.
Surgery.—Three days in each week.
Chemistry.—Four days in the week.
Materia Medica and Pharmacy.—Four days in the week.

Institutes of Medicine and Pathology.—Four days in the week.

Practice of Medicine.—Four days in the week.

Midwifery.—Four days in the week.

Clinical Lectures.—Attendance on Sir Patrick Dun's Hospital during nine months, with three consecutive courses of Clinical Lectures, each of three months' duration. These Lectures are delivered by the Professors, at twelve o'clock. Also, nine months' attendance on some general hospital in Dublin, approved of by the Board, in which clinical instruction in Medicine and Surgery is delivered.

Courses of Three Months' Duration.

Botany.—In the last week of April, and continued during the months of May, June, and July.

Practical Chemistry.

Medical Jurisprudence.

A year's attendance, or an *annus medicus* in the School of Physic, may be kept in three ways: 1. By attending at least two, or not more than three, of the foregoing courses of lectures, which are of six months' duration. 2. By attending one course of six months' and two of three months', duration. 3. By nine months' attendance on Sir Patrick Dun's Hospital, and Clinical Lectures; together with one course of lectures of six months' or, in lieu thereof, two courses of three months', duration.

Three of these courses, at the discretion of the Candidate, may be attended in the University of Edinburgh.

The course of Practical Anatomy and Anatomical Demonstration does not count as a course of lectures.

Every pupil, before he be admitted to attend the Clinical Lectures, must pay the Professor £3 3s. for each three months' Course of Lectures, and shall enter his name with the Treasurer of Sir Patrick Dun's Hospital, and pay him ten guineas, unless he shall have been matriculated in the University of Dublin, or of Oxford, or of Cambridge and shall have continued his studies in Arts, under a Tutor, in one of the said Universities, for the space of *two years at least*, in which case he shall pay the sum of £3 3s. to such Treasurer, for the first half year, with a proportionate sum for any longer period.

The examination for the degree of Bachelor of Medicine is conducted by the Regius Professor of Medicine, the Professor of Surgery in the University, and the Professors of the School of Physic in Ireland.

The days of graduation are Shrove Tuesday and the first Tuesday in July. The Medical examinations terminate on the Tuesday of the preceding week. Candidates having *completed* their Medical education, can procure from the Registrar of the Professors of the School of Physic, a schedule testifying to the correctness of the details of the attendance on Lectures, &c., on producing which a *Licent ad Examinandum* is issued by the Provost and Senior Fellows.

2. Doctor in Medicine.

A Doctor in Medicine must be M.B. of at least three years' standing; and must perform exercises for the degree before the Regius Professor of Physic, in accordance with the Rules and Statutes of the University.

This degree entitles the holder to vote as a University Elector, under the Act 2 & 3 Wm. IV. c. 88, at all elections of Members to represent the University in Parliament.

The Fees payable to the University for these degrees are as follow:—

Bachelor of Medicine.....	£11 15 0
Doctor of Medicine,.....	22 0 0

DIPLOMA IN SURGERY.

The Diploma in Surgery may be obtained by such Students as are matriculated in Medicine, and

have completed at least one year in Arts, on the following conditions:—

1. To complete one year in Arts it shall be necessary to have answered at least one Examination, subsequent to the Junior Freshman year; or to have completed the Junior Freshman year only by passing the Michaelmas Examination of that year, and keeping one previous Term, either by Lectures or by Examination.

2. Students who have not passed an Examination in the Senior Freshman year, will be required to attend one Course of Lectures in Logic. Students who have not passed the Junior Sophister year of the Undergraduate Course will be required to attend one Course of Lectures on Mechanics with the Assistant to the Professor of Natural Philosophy.

3. Students so qualified will be admitted to Examination for the Diploma in Surgery, as soon as they shall have completed the prescribed Curriculum.

4. This Curriculum shall extend over a period of four years, and shall comprise attendance upon the following Course of Lectures in the School of Physic in Ireland:—

Anatomy and Physiology	Three Courses.
Demonstrations and Dissections,	Three Courses.
Theory and Practice of Surgery,	Three Courses.
Practice of Medicine,.....	One Course.
Chemistry,.....	One Course.
Materia Medica	One Course.
Midwifery,.....	One Course.
Practical Chemistry,	One Course each, of three months' duration.
Botany,.....	
Medical Jurisprudence,	One Course each, of three months' duration.

Four of the above-named Courses, together with a Course of Demonstrations and Dissections, may be attended in any School of Medicine recognised by the Board.

Also, attendance for three Sessions, each of nine months' duration, on the practice of any of the following Hospitals, together with attendance on the Clinical Lectures on Medicine and Surgery there delivered:—

1, Richmond, Whitworth, and Hardwicke Hospitals; 2, Meath Hospital; 3, Steevens' Hospital; 4, Jervis-street Infirmary; 5, City of Dublin Hospital; 6, Mercer's Hospital; 7, St. Vincent's Hospital.

Of the Courses of Lectures which are of six months' duration, not more than three can be attended during any one Session.

5. Candidates for the Diploma, who have complied with the foregoing regulations, must pass an Examination before a Court of Examiners, consisting of the Regius Professor of Physic, the University Professor of Surgery, and the Professors of Anatomy, Surgery, Chemistry, Midwifery, and Botany, of the School of Physic.

The Examination of each Candidate will be divided into two parts, one of which shall be devoted to Anatomy and Physiology, Surgical Anatomy, Chemistry, Materia Medica and Toxicology.

the other to the Theory and Practice of Surgery, Operative Surgery, the Practice of Medicine, and Midwifery.

6. Candidates for the Diploma must submit their Certificates and Testimonials of qualification to the Regius Professor of Physic and to the Professors of Surgery, who shall sign the Chart necessary to be laid before the Senior Lecturer and Registrar, previous to the issuing of the *Licent ad Examinandum* to the Professors.

A Fee of £2 10s. is charged on taking the Diploma.

The following Courses of Lectures and of Clinical Study are recommended to Students intending to qualify for the Public Service in the departments:—

1. Ophthalmic Surgery.
2. Military Surgery.
3. Pathological Anatomy.
4. Comparative Anatomy and Natural History.
5. Attendance in an Hospital for the treatment of the Insane.

PRIVILEGES OF MATRICULATED MEDICAL STUDENTS.

The Medical Library at Sir Patrick Dun's Hospital is open on Tuesdays and Fridays, at two o'clock, for the delivery of books to Students, conformably with the regulations of the College of Physicians.

The College Herbarium is open to the public on Wednesdays and Fridays during Term, from 11 to 2 o'clock. Any persons desirous of verifying specimens may obtain admission on Tuesdays and Thursdays, during the same hours, by giving notice to the Curator.

The Botanic Gardens of the University are also open to Matriculated Students.

Medical Students, being Junior or Senior Sophisters on the College Books, and in attendance on two of the winter courses of Medical Lectures, are exempted from the Classics of the Junior Sophister year, and for one of the three optional Courses (Mathematical Physics, Experimental Physics, or Classics) of the Senior Sophister year. To obtain this privilege it is necessary that the Student be Matriculated in Medicine, and that the proper certificates of his attendance on Medical Lectures be submitted to the Senior Lecturer.

Students in Arts, who are also matriculated in Medicine, having their names on the College Books will be permitted to attend one Course free of expense, with each of the University Professors.

No Testimonium, or Certificate of Attendance, will be issued to such Students until after they have proceeded to their first degree in Medicine. On the application for the *Licent ad Examinandum*, the Professors will transmit, direct to the Registrar of the School of Physic, the names of those Students who have qualified themselves. Should the Student who has had the privilege of free attendance desire to obtain an official Testimonium, before proceeding to his Medical degree,

he must, on obtaining it, pay the Professor the usual fee.

By the Act, 40 Geo. III., c. 84, the several Lecturers and Professors of the School of Physic are bound during each Medical Session to return to the Senior Lecturer the names of such Students as have attended their Lectures.

The Queen's University in Ireland.

The Centre or Head of the Provincial Colleges of Belfast, Cork, and Galway, each of which possesses a Faculty of Medicine.

THE SENATE, EXAMINERS, AND PROFESSORS.

Chancellor—The Right Honorable George William Frederick Earl of Clarendon, K.G., G.C.B., &c.

Vice-Chancellor—The Right Honorable Maziere Brady, Lord High Chancellor of Ireland, M.R.I.A. &c.

Senate—His Grace Richard Archbishop of Dublin, D.D., M.R.I.A., &c.; The Right Honorable William Earl of Rosse, K. St. P., M.R.I.A., &c.; the Right Honorable Thomas Spring, Baron Monteagle of Brandon, M.A., F.R.S., Member of Senate of University of London, Comptroller of the Exchequer; the Right Honorable Francis Blackburne, LL.D., V.C.T.C.D., M.R.I.A.; the Right Honorable David B. Pigot, Lord Chief Baron of the Exchequer, M.R.I.A., &c.; the Right Honorable Thomas Wyse; Sir Philip Cramp-ton, Bart., M.D., F.R.S., M.R.I.A., Member of Senate of University of London, &c.; the Rev. P. Shulldham Henry, D.D., President Queen's College, Belfast; Sir Robert Kane, F.R.S., M.R.I.A., President, Queen's College, Cork; Edward Berwick, Esq., President, Queen's College, Galway; Richard Griffith, LL.D., M.R.I.A., Commissioner of Public Works; Dominic J. Corrigan, M.D., M.R.I.A., Physician in Ordinary to the Queen in Ireland; Lieut.-Colonel Thomas Askew Larcom, R.E., LL.D., F.R.S., M.R.I.A., &c.; James Gibson, Esq., A.M., M.R.I.A., Barrister-at-Law; Robert Andrews, Esq., Q.C., LL.D.; the Right Honorable James Henry Monaghan, Chief Justice of the Common Pleas.

EXAMINERS, elected 16th July, 1857.

Greek.—Charles Mac Donall, A.M., Professor, Q.C., Belfast.

Latin.—Bunnell Lewis, Esq., Professor, Q.C., Cork.

English Literature.—George L. Craik, A.M., Professor, Q.C., Belfast.

Logic and Metaphysics.—Thomas W. Moffett, LL.D., Professor, Q.C., Galway.

Mathematics.—George Boole, LL.D., Q.C., Cork.

Natural Philosophy.—John Stevelly, LL.D., Professor, Q.C., Belfast.

Chemistry.—Thomas H. Rowney, Ph.D., Professor, Q.C., Galway.

Anatomy and Physiology.—Robert Harrison, M.D., Professor, T.C.D.

Zoology and Botany.—Vacant.

Modern Languages.—Raymond De Vericour, D. es L., Professor, Q.C., Cork.

Mineralogy, Geology, and Physical Geography.—William King, Professor, Q.C., Galway.

Jurisprudence and Political Economy.—D. Caulfield Heron, LL.D., Professor, Q.C., Galway.

Law.—W. B. Drury, Esq., Barrister-at-Law.

Civil Engineering and Surveying.—Alexander Jack, Esq., Professor, Q.C., Cork.

Agriculture.—Thomas Skilling, Professor, Q.C., Galway.

Celtic Languages.—John O'Donovan, LL.D., M.R.I.A., Professor, Q.C., Belfast.

Medicine.—John C. Ferguson, A.M., M.B., Professor, Q.C., Belfast.
Surgery.—M. H. Collis, M.B.
Materia Medica, Pharmacy, and Medical Jurisprudence.—T. Geoghegan, M.D.
Midwifery and Diseases of Women and Children.—Jos. B. Harvey, A.B., M.D., Professor Q.C., Cork.

PROFESSORS OF THE QUEEN'S UNIVERSITY IN THE SEVERAL QUEEN'S COLLEGES.

PROFESSORS OF	BELFAST.	CORK.	GALWAY.
Greek	Chas. Mac Donnell, A.M.	John Ryall, LL.D., V.P.Q.C.	William Nesbitt, A.M.
Latin	Rev. Chas. P. Reiche, B.D.	Bunnell Lewis, A.M.	Richard Blair Bagley, A.M., Q.U.
History and English Literature	Geo. Lillis Craik, A.M.	Francis	Joseph O'Leary, Barrister-at-Law, V.P.Q.C.
Logic and Metaphysics	Rev. James McCosh, LL.D.	George S. Read, A.M.	Thos. Wm. Moffett, LL.D.
Mathematics	Pres. Guthrie, LL.D.	George Boyle, LL.D.	Geo. Johnston Alliman, LL.D.
Natural Philosophy	John Strevell, LL.D.	John Blyth, M.D.	Arthur H. Curtis, A.M.
Chemistry	Thomas Adams, M.D., F.R.S.		Thomas Henry Rowney, Ph. D.
Anatomy and Physiology	M.R.I.A., V.P.Q.C.	Joseph H. Corbett, M.D., Q.U. L.R.C.S.I.	Charles Croker King, M.D., Q.U., F.R.C.S.I., M.R.I.A.
Natural History	Hugh Canille, A.M., M.D.	Francis	Alexander G. Melville, M.D., M.R.C.S.E., M.R.I.A.
Modern Languages	George Dickie, M.D.		Augustus Senbach, M.D.
Mineralogy and Geology	Mathias J. Frings, Ph. D.	R. De Vertour, D. es L.	William King, Esq.
Jurisprudence & Political Economy	Wyllie T. C. Thomson, LL.D.	Robert Harkness, F.R.S.E., F.G.S.	D. Caulfield Heron, A.M.
English Law	Thos. Ed. Cliffe Leslie, LL.B.	Richard Horner, M.P., A.M.	Hugh Law, A.B.
Civil Engineering	Echlin Molynneux, A.M.	Michael Barry, M.R.I.A.	W. Bindon Blood, A.B., C.E.
Agriculture	John Gotwin, C.E.	Alexander Jack, Esq.	Thomas Skilling, Esq.
Celtic Languages	John F. Hodges, M.D.	Edmund Murphy, A.B.	John O'Driscoll, Esq., A.B., Q.U.
Practice of Medicine	John O'Donovan, LL.D.	Owen Connellan, Esq.	Nich. Colahan, M.D., F.R.S.E.
Practice of Surgery	John Creery Ferguson, A.M., M.B., Hon. F. R. & Q.C.F.	Denis C. O'Connor, A.B., M.D.	Jas. V. Browne, A.B., M.D., L.R.C.S.I.
Materia Medica	Alexander Gordon, M.D.	Dennis B. Bullen, M.D.	Simon M'Coy, F.R.C.S.I.
Midwifery	James Searon Reid, M.D.	Geo. Purcell O'Leary, M.D.	Richard Doherty, M.D., V.P. Dub. Obst. Society.
	William Burden, M.D.	Josiah R. Harvey, A.B., M.D.	

J. JOHNSTONE STONEY, A.M., M.R.I.A.,
 Secretary.

The Queen's University Office,
 Dublin Castle, October, 1857.

DEGREES IN MEDICINE.

1st.—Every candidate for the degree of M.D. shall produce a certificate from the Council of one of the Queen's Colleges, that he has passed a full examination in the subjects of study prescribed in the course of Matriculation for Arts, and has been admitted a matriculated student of the College in the Faculty of Medicine.

Matriculation Examination.—Greek: Xenophon, the Anabasis, Book I.; Grammar.—Latin: One of the following authors:—Virgil, *Æneid*, Book I.; Cæsar, Gallic War, Book V.; Betranslation from English into Latin, of portions of Cæsar.—English: Grammar and Composition.—Mathematics: Arithmetic and Algebra; the First Four Rules of Arithmetic; Vulgar and Decimal Fractions; the Rule of Three; Addition, Subtraction, Multiplication, and Division of Algebraical Quantities; Simple Equations; Geometry, Euclid, Book I.—History and Geography:—History: Outlines of Grecian and Roman History; Geography: Outlines of Ancient and Modern Geography. Students who do not intend to compete for honors may postpone their matriculation to any period of their course.

2nd.—The Curriculum of Medical Instruction shall extend over a period of at least four years, and shall be divided into two periods of at least two years each.

3rd.—The first period shall comprise attendance on the following courses of medical lectures:—Chemistry, Botany and Zoology, Anatomy and Physiology, Practical Anatomy, Materia Medica and Therapeutics, six months each.

4th.—The second period shall comprise attendance on the following courses of medical lectures:—Anatomy and Physiology, Practical Anatomy, Theory and Practice of Surgery, Midwifery and Diseases of Women and Children, Theory and Practice of Medicine, six months each; Medical Jurisprudence, three months.*

5th.—In addition to the above courses of lectures, candidates shall have attended, during the first period of the above curriculum—Practical Chemistry in a recognised laboratory, three months; Medico-Chirurgical Hospital, recognised by the Senate, containing at least sixty beds, together with Clinical Lectures therein delivered, at least two each week, six months.

6th.—And during the second period—Practical Midwifery at a recognised midwifery hospital, with the Clinical Lectures therein delivered, for a period of three months, in a hospital containing not less than fifteen beds; Practical Pharmacy, three months; Medico-Chirurgical Hospital, with Clinical Lectures, eighteen months.

7th.—Candidates, before being admitted to the degree of M.D., shall pass two examinations; the first examination comprising the subjects of the first period of the curriculum; the second comprising subjects of the second period of study. It shall be competent for students to present themselves for their first examination at the termin-

* The 25th of November in each year is the last day of entering for the six months' course of lectures in the above curriculum. All the lectures are recognised at the Queen's University in Ireland; by the Universities of London, Glasgow, Aberdeen, and St. Andrew's; the Colleges of Surgeons of Dublin, Edinburgh, and London; by the Apothecaries' Companies; by the Army, Navy, and East India Medical Boards, &c., &c.

tion of the first period of the curriculum, or at any other period to be fixed by the Senate, previous to their undergoing the second examination.

8th.—By the Charter of the Queen's University, candidates are required to have attended at least one-third of the courses of Medical Lectures in some one of the Queen's Colleges. For the remainder of the courses of medical lectures authenticated certificates will be received from the Professors or Lecturers in Universities, Colleges, or Schools recognised by the Senate of the Queen's University in Ireland.

9th.—Candidates will also be required to have attended, in some one of the Queen's Colleges, lectures on one modern language, for six months, and lectures on Natural Philosophy for six months.

10th.—The examinations will be conducted principally by printed papers, to which written answers shall be given; but the examiners shall also be at liberty to add such *viva voce* examination on the subjects of the written paper, and to call for such demonstrations and experiments, as they may deem necessary.

11th.—The above regulations will be binding on all students commencing their medical studies on or after the 1st October, 1852; but students already engaged in their medical studies are at liberty either to complete their courses according to the ordinances of the 30th June, 1850, or according to the present ordinance.

King and Queen's College of Physicians in Ireland.

President—Sir Henry Marsh, Bart.

Censors—Dr. Aquilla Smith, *Vice-President*; Dr. Henry Kennedy, Dr. J. M. Nelligan; Dr. Robert Mayne.

Treasurer—Dr. Henry Law Dwyer.

Registrar—Dr. William Edward Steele.

Librarian—Dr. George A. Kennedy.

Professor of Midwifery—Dr. Fleetwood Churchill.

Professor of Medical Jurisprudence—Dr. T. Brady.

Examiners in Midwifery—Dr. William O'B.

Adams, Dr. H. Law Dwyer, Dr. John Ringland.

Inspectors of Apothecaries' Shops—The Censors.

Candidates for the Licence, who have completed the following course of education, are admissible to examination:—Anatomy, Chemistry, Practice of Medicine, Materia Medica, Institutes of Medicine, Midwifery, Demonstrations and Dissections, of each six months; Botany, Medical Jurisprudence, of each three months; Medico-chirurgical Hospital, two years and a half; and Lying-in Hospital, six months. Graduates in medicine of any University in the United Kingdom, and Surgeons of four years' standing or upwards, are admissible to examination on producing their diplomas. Surgeons under four years' standing are required to have attended Botany, Institutes of Medicine, and a

Lying-in Hospital. Candidates are required to undergo two days' examination on the above subjects, except medical graduates and surgeons of seven years' standing, who are examined in the subjects of the second day only—viz., Practice of Medicine, Institutes of Medicine, and Midwifery. Surgeons who are A.B.'s, in addition to these subjects, are examined also in Botany and Materia Medica. Members of any Apothecaries' Company are ineligible for admission to the licence. Licentiates of three years' standing, or of one year if forty years of age, who are graduates of the Universities of Oxford, Cambridge, or Dublin, are alone eligible for election to the fellowship. Fee for the licence, £30. Fee for the fellowship, £20.

Royal College of Surgeons, Ireland.

President—Hans Irvine.

Vice-President—James W. Cusack.

Secretary to the College—Edward Hutton.

Council—Sir Philip Crampton, Bart., Alexander Read, Arthur Jacob, Thomas E. Beatty, Wm. Hargrave, Andrew Ellis, Robert C. Williams, Robert Adams, James Barker, William Colles, John H. Power, J. S. Hughes, Edward Hutton, Robert Pentland, Samuel G. Wilmot, A. E. Tabuteau, A. P. Bannon, Peter Shannon, Rawdon Macnamara.

Honorary Secretary to the College—Edward Hutton.

Secretary to the Council—H. Maunsell.

Registrar—J. Brennan.

Court of Examiners—Josiah Smyly, Charles Fleming, R. Tuohill, M. H. Stapleton, Richard G. H. Butcher, B. W. Richardson, Edward A. Stoker.

Examiners in Midwifery—Wm. Jameson, Robt. Johns, Jerome Morgan.

PROFESSORS.

Anatomy and Physiology—Dr. Jacob.

Descriptive Anatomy—Dr. J. H. Power and Dr. Bevan.

Surgery—W. H. Porter and W. Hargrave, Esqrs.

Medicine—Dr. C. Benson.

Chemistry—Dr. W. Barker.

Materia Medica—Dr. R. C. Williams.

Midwifery—Dr. Sawyer.

Medical Jurisprudence—Dr. T. G. Geoghegan.

Botany—Dr. A. Mitchell.

Practical Chemistry—Dr. Barker.

Comparative Anatomy—Dr. Jacob.

Regius Professor of Military Surgery—Jolliffe Tufnell, Esq.

Logical and Inductive Science (for the Army Medical Department)—Dr. John Murray.

The Royal College of Surgeons in Ireland grants two different Diplomas—one conferring the rank of Fellow, and the other that of Licentiate. Fel-

lows of the College are members of the Corporation, and are admitted by examination.

Fellowship—The candidates for the Fellowship must be twenty-five years of age, and if not a graduate in Arts of some University, must answer a classical examination, which is generally confined to the principal books read for entrance into Dublin University. He must have been six years engaged in professional study, three of which must have been in Dublin; and he must also have been a house surgeon or dresser in an hospital. He is required to attend lectures on anatomy and physiology, and on surgery, with dissections, during three seasons; chemistry during two; and practice of medicine, materia medica, midwifery, medical jurisprudence, comparative anatomy, natural philosophy, and botany for one course each. His hospital attendance must be three years at least. Bachelors of Arts, after five years study, are admitted to examination on compliance with the above regulations, and Licentiates of the College of ten years' standing are also admitted, although they may not have been educated in strict conformity with them.

Letters Testimonial.—The candidate for Letters Testimonial is required to become a Registered Pupil, and to pass a classical examination. He is also required to prove that he has studied for three years in the metropolitan schools (nine months in each year), and for a fourth year either there or any where else, where he might have obtained professional information. His hospital attendance is by the bye-law declared to be three years "where clinical instruction is given," and all the Dublin hospitals are recognized. Credit is given for attendance on provincial hospitals, but it is expected that while the pupil is in attendance on lectures in Dublin, he shall at the same time attend an hospital there. Candidates for Letters Testimonial are also required to prove that they have attended three courses of lectures on anatomy and physiology, surgery, and practical anatomy (being demonstrations with dissections), two courses on chemistry, and one course on the practice of medicine, materia medica, midwifery, and medical jurisprudence.

Candidates both for the Fellowship and Letters Testimonial are examined on the practice of Medicine and Pharmacy as well as on Surgery. The diploma is a full qualification as General Practitioner, entitling the holder of it to be appointed to county infirmaries, fever hospitals, dispensaries, poorhouses, and all other medical charities; and Licentiates of the College can dispense medicines to their own patients, but they cannot keep open shops, or retail drugs, or compound the prescriptions of other practitioners, without the licence of the Apothecaries' Company. Both Fellows and Licentiates are authorized by law and permitted by the charter, to compound and dispense medicines for their patients in the hospitals, dispensaries and poorhouses to which they are attached.

None but Fellows and Licentiates of this College are eligible to be appointed Surgeons of County Infirmaries in Ireland.

The College of Surgeons of Ireland is empowered by charter to grant a diploma in Midwifery to its own Fellows and Licentiates only, and does not recognize any of them as midwifery practitioners, or mark them as such in the printed lists of the College, unless they have had that diploma granted to them.

Certificates granted by professors in Universities which do not receive the certificates granted by the professors in the College of Surgeons, are not recognized as qualification from candidates for either of the diplomas.

Returns of the names of those who have entered to attend lectures are required to be forwarded to the College by professors and lecturers on the 25th of November, and at such other periods during the session as the Council may think fit, which returns must certify that the students named therein are then attending regularly; and no certificate is received from any candidate for either of the diplomas, unless his name appears in the returns corresponding to the date of such certificate. Professors or lecturers neglecting or refusing to make such returns, or who grant certificates to any student whose name has not been inserted in such returns, are not recognized.

The following special or exceptional Bye-laws and ordinances have been enacted:—

That to enable Surgical Students to devote more time to Hospital Attendance and Dissection during the winter session, the lectures on Materia Medica, Medical Jurisprudence, Practical Chemistry and Botany, shall be delivered during the summer session in the School of the College and in the schools recognized by the College; and certificates granted subsequent to the 30th of April, 1851, shall not be received as qualification for Letters Testimonial unless issued in conformity with this regulation.

Candidates for Letters Testimonial, who shall have attended metropolitan hospitals during three winter sessions of six months each, shall be considered to have performed sufficient hospital attendance, if they shall be able to produce certificates of regular daily attendance during a like number of months at a county infirmary, or provincial surgical hospital, containing at least fifty beds; provided the surgeons of such infirmaries or hospitals shall make returns to this college, in the months of May and November in each year, of the number of students so attending.

That the Council being anxious to encourage liberal education among candidates for Fellowship and Letters Testimonial, in future all graduates in Arts of the University of Dublin, being registered pupils of the College of Surgeons, shall be admitted to the examinations for Fellowship and Letters Testimonial, provided they produce the certificate of surgical education required by the bye-laws, and of such course of education the several certi-

ificates of the School of Physic now required by the regulations of the University, to be produced by candidates for the degree of Bachelor of Medicine, shall be received as part.

That candidates for Letters Testimonial of the College who shall produce certificates from the Council of one of the Queen's Colleges, that they have passed a full examination in the subjects of study prescribed in the course of matriculation for arts, and have been admitted matriculated students of the College in the Faculty of Medicine, shall be admitted to examination; provided they shall produce the certificates of surgical education required by the bye-laws of this College, and of such course of education the several certificates of the Professors of the Queen's Colleges now required by the Senate of the Queen's University to be produced by candidates for the degree of Doctor of Medicine, shall be received as part; and also provided, that of the four years during which they shall have been engaged in the acquisition of professional knowledge, two shall have been passed in attendance on lectures and hospitals in Dublin, London, or Edinburgh.

Apothecaries' Hall of Ireland.

Governor—Dr. Charles Henry Leet.

Deputy-Governor—Dr. Madden, Sen.

Court of Examiners—Drs. Shaw, John Betty, Edward H. Bolland, Charles Holmes, William Madden, jun., William D. Moore, Robert Mullett, Henry P. Nolan, George B. Owens, John Shea; Mr. Thomas Collins, Mr. Jerome O'Flaherty, Dr. John McMunn.

Secretary—Dr. Charles H. Leet.

Laws regarding the Education of Apothecaries.

Every candidate must undergo two separate examinations—one for the certificate of apprenticeship, the other for the licence to practise.

Every candidate for the certificate of apprenticeship will be examined in the following books:—In Latin: the Catiline War of Sallust, and the first three books of the *Aeneid* of Virgil. In Greek: the Gospel of St. John and the first twenty Dialogues of Lucian, or the first two books of Homer's *Iliad*. In French: Telemachus, or the History of Charles XII. In Science: the first two books of Euclid, and Algebra to the end of Simple Equations. Also in Arithmetic (especially decimals), and in English Composition.

Every candidate for the Licence to Practise as an Apothecary must lay before the Court—1, The certificate of apprenticeship; 2, The indenture of apprenticeship of five years, enrolled according to the Act of Parliament, and bearing the certificate of the Licentiate Apothecary to whom he has been indentured, of a good moral character, and of having fulfilled the period of his apprenticeship; 3, Certificates, duly signed, that he has diligently at-

tended the following lectures, delivered at some school of medicine recognised by the Court:—Anatomy and Physiology, Demonstrations and Dissections, of each for twelve months; Practical Chemistry,* Botany, and Natural History, three months; Chemistry, Materia Medica,† Theory and Practice of Physic, Surgery, Midwifery, and the Diseases of Women and Children, six months; Medical Jurisprudence, three months.

Certificates of attendance for the entire period of eighteen months, on the medical and surgical practice in an hospital or hospitals recognised by the Court, and where clinical instruction is regularly given; also of attendance upon thirty cases of midwifery.

Candidates for the Licence to Practise are required to be expert in the analysis of poisons, in the detection of adulteration in drugs, and in the use of the microscope.

The examination for the Licence to Practise as an Apothecary will be as follows:—In Chemistry and General Physics; Pharmacy, theoretical and practical; Materia Medica and Therapeutics; Natural History and Medical Botany; Anatomy and Physiology; the Theory and Practice of Medicine; Midwifery; Medical Jurisprudence.

The Council require that every indenture of apprenticeship be enrolled at the Hall within six months of the date of its execution; and that the date of the diploma of the master to whom the apprentice is being bound be furnished at the same time; and that this rule be adhered to on every transfer of such indenture, on pain of forfeiture of the time served.

NAVAL MEDICAL SERVICE.

The candidate must produce a diploma from one of the Colleges of Surgeons, also proof of having received a preliminary classical education; of having been engaged for not less than six months in practical pharmacy; that his age be not less than twenty years, nor more than twenty-six; that he has actually attended an hospital in London, Edinburgh, Dublin, Glasgow, Aberdeen, Manchester, or Bristol, for eighteen months subsequently to the age of eighteen; that he has been engaged in actual dissections twelve months; that he has attended the following lectures—Anatomy, eighteen months; or general anatomy, twelve months, and comparative anatomy, six months; surgery, eighteen months; or general surgery, twelve months, and military surgery, six months; theory of medicine, six months; practice of medicine, twelve months; (if the lectures on the theory and practice of medicine be given in conjunction, then the period required is eighteen months); clinical lectures on the practice of medicine, six months; practice of surgery, six months; chemistry, six months; or lectures on chemistry, three months, and practical chemistry, three months; materia medica,

* The Practical Chemistry must be attended in a laboratory, and no certificate will be received by the Court, that does not testify that the candidate has prepared the several pharmacopoeial preparations which are usually made in the laboratory.

† The Materia Medica, if attended in summer, must consist of two courses of three months' duration each.

six months; midwifery, six months, with certificates of the number of cases attended; botany, three months.

By an Admiralty circular, dated 1855—1. Assistant-Surgeons of the Royal Navy are to rank with mates, according to the dates of their respective commissions, and will take relative rank with lieutenants and assistant-surgeons in the army. 2. Assistant-surgeons serving in ships commanded by captains or commanders are to mess with the ward-room officers; and those serving in vessels commanded by lieutenants or masters are to mess in the gun-room with the other officers. 3. Cabins are to be assigned to assistant-surgeons whenever the service admits.

ARMY MEDICAL DEPARTMENT.

The name of no gentleman can be placed on the list of candidates who does not possess a diploma in surgery, with the following testimonials:—Eighteen months' hospital; twelve months' anatomy; twelve months' practical anatomy; six months' physiology; twelve months' surgery, or (what is preferred) six months' surgery and six months' military surgery; eight months' clinical surgery; twelve months' practice of physic, or six months' practice of physic and six of general pathology; eight months' clinical lectures on ditto, the same as required in surgery; twelve months' chemistry; six months' practical chemistry; three months' botany; three months' materia medica; three months' practical pharmacy, or apprenticeship; three months' natural history; three months' midwifery; three months' practical midwifery; one course natural philosophy; one course logic. Candidates must be unmarried, not beyond twenty-seven years of age, nor under twenty-one years. The certificate of the teacher of practical anatomy must state the number of subjects or parts dissected by the pupil. All candidates for medical appointments are required to be conversant with Cullen's Nosology.

By the rules for the future regulation of the promotion and retirement of officers in the army (p. 5, s. 18), dated October 6, 1854:—"No medical candidate who has not passed his examination at the Royal Colleges of Surgeons of London, Edinburgh, or Dublin, shall be eligible for the commission of assistant-surgeon; and he must have served as such on full pay five years before he shall be eligible for promotion to the rank of staff-surgeon of the second class."

REGULATIONS FOR THE ADMISSION

OF CANDIDATES FOR THE APPOINTMENT OF ASSISTANT-SURGEON IN THE

SERVICE OF THE EAST INDIA COMPANY.

All natural-born subjects of her Majesty, between 22 and 28 years of age, and of sound bodily health, may be candidates for admission into the service of the East India Company, as Assistant Surgeons.

They must subscribe and send in to Dr. Scott, the Physician to the Honorable East India Company, ten days before the period fixed for each examination, a declaration to the following effect:—

"I (Christian and Surname at full length) a candidate for employment as an Assistant Surgeon in the service of the East India Company, do hereby declare that I was _____ years of age on the _____ day of _____ last,

and that I labour under no constitutional disease or physical disability that can interfere with the due discharge of the duties of a medical officer; and I also attest my readiness to proceed on duty to India within three months of receiving my appointment."

This declaration must be accompanied by the following documents:—

1. Proof of age, either by extract from the register of the parish in which the candidate was born, or by his own declaration, pursuant to the Act 5 & 6 William IV., cap. 62.

2. A certificate of moral character from a magistrate, or a minister of the religious denomination to which the candidate belongs, who has personally known him for at least two preceding years.

3. A diploma in surgery (or a degree in medicine, provided an examination in surgery be required for such degree) from some body competent by law to grant or confer such diploma or degree.

4. A certificate of having attended two courses of lectures, of six months each, on the practice of physic, and of having attended, for six months, the practice and clinical instruction of the physicians at some hospital containing at least, on an average, one hundred in-patients; or of having attended one course of lectures, of six months, on the practice of physic, and clinical instruction for twelve months.

5. A certificate of having attended, for three months, the practical instruction given at one of the public asylums for the treatment of the insane.

6. A certificate of having attended, for three months, one of the institutions, or wards of an hospital, especially devoted to the treatment of ophthalmic disease.

Candidates who may not have been able to attend the practice of an asylum for the insane, or of an ophthalmic hospital, for three months previous to their offering themselves for examination, will not be excluded from examination, but will, if successful in obtaining recommendation for appointments, be required to produce certificates of having attended such practice during the interval between the examination and the time of proceeding to India.

7. A certificate of having attended a course of lectures on midwifery, and of having conducted at least six labours.

8. A certificate of having acquired a practical knowledge of cupping.

Candidates may also, at their option, send in certificates of attendance at any hospitals, or on any course of lectures, in addition to the above. Attendance on a course of military surgery, and the practical study of surgical operations on the dead body, are recommended.

The examination will include the following subjects:

1. Surgery in all its departments.
2. Medicine (including the Diseases of Women and children), Therapeutics, Pharmacy, and Hygiene.
3. Anatomy and Physiology, including Comparative Anatomy.
4. Natural History, including Botany and Zoology.

The following are the books recommended in—

Zoology and Comparative Anatomy—Outlines of the Structure of the Animal Kingdom, by Rymer Jones; or Cours Elementaire d'Histoire Naturelle, par M. Edwards.

Botany—Lindley's School Botany, or Lindley's Elements of Botany.

The examination will be conducted—1. By means of written questions and answers. 2. By object examinations and experiments, when the subject admits of such tests. 3. By practical examination of patients, and by operations on the dead body. 4. By *visu voce* examination.

The persons who shall be pronounced by the examiners to be the best qualified in all respects will be appointed to fill the requisite number of appointments as Assistant Surgeons in the East India Company's Service; and so far as the requirements of the service will permit, they will have the choice of the Presidency in India to which they shall be appointed, according to the order of merit in which they stand on the list resulting from such examination.

All Assistant Surgeons are required to subscribe to the Military or Medical, and Medical Retiring Funds, at the Presidencies to which they may be respectively

appointed, and to the Military Orphan Society also, if appointed to Bengal.

All Assistant Surgeons who shall neglect or refuse to proceed to India under the orders of the Court of Directors, within three months from the date of their appointment, will be considered as having forfeited it, unless special circumstances shall justify a departure from this regulation.

A copy of these regulations, and any further information, may be obtained on application to the Secretary of the Military Department, East India House.

The examinations will take place in the months of January and July in each year, and due notice will be given, by public advertisement, of the days appointed, and of the probable number of candidates to be selected.

The Examiners for Assistant Surgeons in the Honorable East India Company's Service having received many inquiries as to the object and extent of the examination in Comparative Anatomy, Zoology, and Botany, have considered it desirable to announce that their objects are—

1. To ascertain who of the candidates have devoted special attention to any of these sciences, and are hence qualified to undertake duties requiring a knowledge of them, as well as the general duties of their profession. Proficiency in these sciences will, in classifying the candidates by merit, be entitled to great consideration.

2. To encourage all candidates to acquire an elementary knowledge of the structure and affinities of the principal natural families of animals and of plants, with the general plan upon which these are constructed, and the functions and relations of their most important organs.

3. To promote the study of natural history, as a most important adjunct or preliminary to a liberal medical education; that of Comparative Anatomy, Zoology, or Botany, if properly cultivated, by means of specimens, for even a short period, being eminently calculated to develop habits of close observation, and to strengthen those powers of reasoning upon observed facts, which must be habitually exercised by medical men everywhere, but which must be exercised with the greatest energy and promptitude by those who practise in a tropical climate, and who are often thrown wholly upon their own resources.

The general examination in these sciences will be elementary, and will embrace a very limited range of technical terms. At the written examination a considerable number of questions will be put, with the view of allowing each candidate to select such subjects as he has attended to, and thereby of enabling the examiners to ascertain the particular departments of science in which the verbal examination should be conducted.

With those candidates who have attained proficiency in any branch of these sciences, the verbal examination will be pursued in the branch selected, so as to ascertain the full extent of their knowledge.

MEMORANDUM AS TO THE PAY AND ALLOWANCES OF MEDICAL OFFICERS IN THE EAST INDIA COMPANY'S SERVICE.

Pay and allowances and time of service commence from date of arrival at the Presidency to which they are appointed.

On first arrival, and whilst attached to the General Hospital at the Presidency, they are granted pay and allowances (inclusive of quarters valued at Rs. 25 per month) amounting per month to Rs. 220.

When posted to do duty with corps, they receive the following allowances:—

		Within 200 miles of the Presidency.		Beyond 200 miles from the Presidency.	
		Per Month.		Per Month.	
Including conveyance allowance of Rs. 30 a month.	Horse Artillery	R.	A.	R.	A.
	and Cavalry,	364	6	395	4
	Foot Artillery,	264	4	295	12
	Infantry, ..	255	12	286	10

When in charge of corps as Assistant-Surgeons, having passed the prescribed examination in native languages:—

Including a Staff Salary of Rs. 165 a month.	Horse Artillery and Cavalry,	R.	A.	R.	A.
	Foot Artillery,	499	6	530	4
	Infantry, ..	399	4	430	12
	Infantry, ..	390	12	421	10

When in charge of corps as Surgeons, having passed the prescribed examination in native languages:—

Including a Staff Salary of Rs. 300 a month.	Horse Artillery and Cavalry,	R.	A.	P.	R.	A.	P.
	Foot Artillery,	821	11	4	863	0	4
	Infantry, ..	692	5	0	733	10	0
	Infantry, ..	674	1	0	715	6	0

Surgeons and Assistant-Surgeons of European corps are granted, in addition, an allowance of Rs. 25 per month for every 100 Europeans under their charge.

Surgical instruments are provided by Government.

FURLONGHS.

On Private Affairs—

For two years, after ten years' service

in India, with pay, if a Surgeon, .. 10s. 6d. a day.

If an Assistant Surgeon, .. 6s. 6d. "

A second furlough for two years, after expiration of ten years from date of return to duty from first furlough, with pay as above.

On Sick Certificate—

For eighteen months, with Indian pay and allowances for six months; for the remaining time, with furlough pay as above. Time may be extended on renewed medical certificate, with pay, for three years in the whole. Assistant Surgeons returning to England on sick certificate receive Rs. 1,200 passage-money.

RETIRING PENSIONS.

After 17 years' service ..	£191 per annum.
" 21 ..	250 "
" 25 ..	300 "
" 29 ..	365 "
" 32 ..	500 "
" 35 ..	700 "

The full time of service must be completed in each case. Out of that time leaves of absence in India or Europe, or elsewhere, to the extent of one year and eight months in seventeen years, two years in twenty years, three years in twenty-five years, and four years in thirty years, will be allowed to count as service.

Medical Officers compelled to quit the service by ill health, before they are entitled to retiring pensions as above, may retire on the following rates of pension, viz:—

Assistant Surgeons, after six years'

service in India ... £54 15 per annum.

" " ten " ... 73 0 "

And if they have attained the rank

of Surgeon ... 127 15 "

Assistant Surgeons compelled to quit the service by wounds received in action, or by ill health contracted on duty, after three years' service in India, are permitted to retire on £73 per annum.

WIDOWS' PENSIONS FROM LORD OLIVE'S FUND.

Widow of a Member of the Medical Board, on declaration that the deceased Officer was not possessed of or entitled to the sum of ...	Per Annum.
Do. of Superintending Surgeon	£4,000 ... £114 1 8
Do. of Surgeon ..	3,000 ... 91 5 0
Do. of Assistant Surgeon	2,000 ... 45 12 6
	1,000 ... 22 16 8

Note—For information respecting the Pensions to Widows and Children, and other advantages, from the Military, Medical, and Orphan Funds; also for information as to the Annuities to Retired Medical Officers from the Medical Retiring Funds; and as to the rates of subscriptions, &c., applicants are referred to the Agents of those Funds respectively, viz. :—

Bengal Military Fund—Lieut.-Col. H. B. Henderson, Old Jewry Chambers.

Bengal Orphan Society—Lieut.-Col. W. Turner, 69, Cornhill.

Bengal Medical Fund—Messrs. Coutts & Co., Strand.

Madras Military Fund—Messrs. Grindlay & Co., 68, Cornhill.

Madras Medical Fund—Messrs. Alexander, Fletcher, & Co., King's Arms Yard.

Bombay Military Fund, and Bombay Medical Fund—Messrs. Forbes, Forbes, & Co., King William-street.

The following Medical Degrees have been conferred by the UNIVERSITY OF TRINITY COLLEGE during the present year.

M.D.

Daly, Andeon. Law, Robert. M'Donnell, Robert.

M.B.

Potter, John
Townsend, Edward R.
Hope, William A.
Bagot, Charles
Foster, William S.
Ussher, Henry

Ashton, William
Pollock, James F.
Wilson, James
Quinlan, Francis J. B.
Carson, Richard B.

The names of those who obtained Degrees and received Certificates at the Queen's University have been already announced. See page 320.

List of gentlemen who obtained the Fellowship and Diploma of the ROYAL COLLEGE OF SURGEONS of Ireland during the present year :—

FELLOWS.

White, Robert P., Roundtown, county Dublin
Reynolds, Francis
Kirkpatrick, John R., Dublin
Morgan, John, Dublin
Doyle, James Thomas Joseph, H.E.I.C.S.
O'Doherty, Kevin Izod, Dublin

LICENTIATES.

Ashton, William, Doneraile, County Cork
Burke, John Ower, Headford, County Galway
Barber, Thomas, Dublin
Boyd, William Cathcart, Dublin
Bradshaw, John, Thurlis
Bennett, Thomas, Oldtown, Templemore
Bagot, Charles, Fontstown Glebe, County Kildare
Creagh, William, Dublin
Chapman, William Samuel, Rathgar, County Dublin
Colahan, Thomas Nicholas Whistler, Galway
Comyn, John Sarsfield, Woodstock, Galway
Cardiff, J. B., Bridgetown, Wexford
Dyas, William, Kells, County Meath
Daly, John Joseph, Tuam
Eames, Chatham, Booterstown, County Dublin
Fleming, William, Finch-road, Douglas

Farrelly, James, Bailieboro' County Cavan
Fagan, Richard, Rathfriland
Ffolliott, Frederick, Oldcastle, Westmeath
Fitzmaurice, Edward, Duagh House, County Kerry
Ferguson, Austin J., Dublin
Gardiner, W. A., Parkview, Salford, Manchester
Gray, John, Calcutta
Greene, Francis, Urlingford, County Kilkenny
Gray, Nicholas L., Tinny Park, Kilkenny
Hanly, William Francis, Nenagh, County Tipperary
Hessian, Thomas Oliver, Tuam
Helsham, John James, Kilkenny
Irvine, Alexander, Lisnagore, Louthwestown
Keogh, Joseph Richard, Dublin
Kearney, Edward Barrett, Dublin
Kinahan, C. James, Scariff, county Clare
Lane, J. W., Newtownlimavady, County Derry
Lamb, John Alexander, Dublin
Leonard, Lucas, Dublin
Matthew, Charles James, Cork
Murray, Henry, Hillsborough, County Down
McNalty, G. William, Sandymount, County Dublin
Macgrath, Edward John, Ennis
Mackay, Alexander, Dublin
McDonough, John, Killarney
McCormack, John, Donegal
Morris, T. J., Lifford, County Donegal
Maxwell, Huston, Bailieboro'
Maccrossan, Thomas, Omagh
Mullan, W. J., Dungannon, County Tyrone
Nowlan, James Joseph, Ballina, County Mayo
O'Brien, T. M. C., Newcastle West, Limerick
Oliver, W. S., Brookville, Limerick
Power, W. J. C., Killenaule, County Tipperary
Potter, John, Kilkenny
Quinlan, Michael, Castleisland, County Kerry
Richmond, Alexander, Poynts Pass, County Armagh
Switzer, Bamlet Walker, Kildare
Taylor, Joseph M., Hillbrook House, Castleknock
Tandy, Edward, Dublin
Tate, Robert, Manorhamilton, County Leitrim
Walker, David, Belfast
Wade, Frederick William, Beltrab, County Cavan
Wilson, Thomas George, Fivemiletown
Wills, Caleb, Carrick-on-Shannon
Whittaker, John Henderson, Ballina, County Mayo
Yorke, Christopher Francis, Galway

We have given in detail the requirements of the Universities and Colleges in Ireland empowered to grant Medical Degrees, Diplomas, or Licences to Practice Medicine or Surgery, and also of the Apothecaries' Hall of Ireland. The Chart which will be found on next page, will supply all information as to the requirements of Universities and Colleges in England and Scotland for medical and surgical qualifications; it also enumerates the various Certificates which the different branches of the Public Service deem necessary.

The other Charts will be found a daily and hourly Hospital and School Guide, as they supply a tabular list of the Medico-Chirurgical Hospitals of Dublin, the various Medical Schools, and the Physicians and Surgeons connected with each. A list of the Hospitals and Schools in Dublin for special medical instruction is also given.

MEDICAL SCHOOLS OF DUBLIN, 1857-58.

WINTER SESSION.	Anatomy and Physiology.	Descriptive Anatomy.	Demonstrations and Dissections.	Surgery.	Practice of Medicine.	Materia Medica and Therapeutics.	Chemistry.	Midwifery.	Institutes of Medicine and Pathology.	Military Surgery.	Operative Surgery.
SCHOOL OF PHYSIC, TRINITY COLLEGE, DUBLIN	Dr. Harrison	Dr. Barton Dr. Egan	Dr. Barton Dr. Egan	Dr. Smith	Dr. Banks	Dr. Osborne	Dr. Apjohn	Dr. Churchill	Dr. Law	..	Dr. Smith Dr. Barton
ROYAL COLLEGE OF SURGEONS ..	Dr. Jacob	Dr. Power Dr. Bevan	Mr. Morgan Mr. Hargrave Mr. Mapother Mr. Colles	Mr. Porter Mr. Hargrave.	Dr. Benson	Dr. Williams	Dr. Barker	Dr. Sawyer	..	Dr. Tubnell	Mr. Porter Mr. Hargrave
DUBLIN ORIGINAL SCHOOL OF MEDICINE	Dr. Mason Dr. T. H. Led- wich	Dr. T. H. Led- wich. Dr. E. Ledwich Dr. O'Doherty Dr. Lane	Dr. Mason Dr. T. H. Ledwich Dr. E. Ledwich Dr. O'Doherty Dr. Lane	Mr. Tagert Dr. T. H. Led- wich	Dr. Lees	Dr. Wharton	Dr. Cameron	..	..	..	Mr. Tagert Dr. T. H. Led- wich
RICHMOND HOSPITAL (OR CAR- MICHAEL) SCHOOL OF MEDICINE	Dr. M'Dowd	Dr. M'Donnell Dr. Curran	Dr. Curran Dr. Jennings Dr. Davies	Mr. Hamilton	Dr. Mayne	Dr. Macnamara	Dr. Davy	Dr. Denham	..	..	..
CATHOLIC UNIVERSITY SCHOOL OF MEDICINE	Dr. Hayden Dr. Cryan	Dr. Hayden Dr. Cryan	Mr. Tyrrell Dr. Quinlan	Mr. Ellis	Dr. Lyons	Dr. MacDermott	Dr. Sullivan	..	..	..	..
STEEVEN'S HOSPITAL SCHOOL OF MEDICINE	Mr. S. A. Cusack	Dr. E. Hamilton	Dr. Minchin Dr. Potter	Mr. Colles Mr. Wilnot	Dr. Freke Dr. Burke	Dr. Gordo	Mr. Warren	Dr. Hardy	..	..	..

SUMMER SESSION.	Practical Anatomy.	Botany.	Practical Chemistry.	Medical Jurisprudence.	Materia Medica.	Natural History.	Logic.	Natural Philosophy.	..
SCHOOL OF PHYSIC, TRINITY COLLEGE, DUBLIN	Dr. Barton Dr. Egan	Dr. Harvey	Dr. Apjohn	Dr. Brady	..	..	..	..	..
ROYAL COLLEGE OF SURGEONS ..	Mr. Morgan Mr. Hargrave Mr. Mapother Mr. Colles	Dr. Mitchell	Dr. Barker	Dr. Geoghegan	Dr. Williams	Dr. Mitchell Dr. Jacob	Dr. Murray	..	..
DUBLIN ORIGINAL SCHOOL OF MEDICINE	Dr. Mason Dr. T. H. Ledwich Dr. E. Ledwich Dr. O'Doherty Dr. Lane	..	Dr. Cameron	Dr. Travers	Dr. Wharton	..	..	..	..
RICHMOND HOSPITAL (OR CAR- MICHAEL) SCHOOL OF MEDICINE	Dr. Curran Dr. Jennings Dr. Davies	Dr. Fraser	Dr. Davy	* Dr. O'Reilly	Dr. Macnamara	Dr. Fraser	..	..	..
CATHOLIC UNIVERSITY SCHOOL OF MEDICINE	Mr. Tyrrell Dr. Quinlan	..	Dr. Sullivan	Dr. MacSwiney	Dr. MacDermott	..	..	Mr. Henesey	..
STEEVEN'S HOSPITAL SCHOOL OF MEDICINE	Dr. Minchin Dr. Potter	..	Mr. Warren	..	Dr. Gordon	..	..	..	..

THE MEDICO-CHIRURGICAL HOSPITALS OF DUBLIN.

Names of Hospitals.	No. of Beds Occupied.	No. of Intern Patients annually treated.	Physicians.	Surgeons.	Particulars.
THE RICHMOND, WHITWORTH, and HARDWICKE HOSPITALS	312	4743	Dr. Corrigan Dr. Banks Dr. M'Dowel Dr. Gordon	Dr. Hutton Dr. Adams Mr. Hamilton Dr. Fleming Dr. Smith	For particulars, see Advertisement, page 2.
STEEVENS' HOSPITAL ...	250	2432	Sir H. Marsh Dr. Croker Dr. Freke Dr. Burke	Mr. Cusack Mr. Colles Mr. Wilmot	For particulars, see Advertisement, p 5.
MEATH HOSPITAL ...	102	1226	Dr. Stokes Dr. Lees	Sir P. Crampton Mr. Porter Mr. Smyly Mr. Rynd Mr. G. H. Porter Mr. M. H. Collis	For particulars, see Advertisement, page 5.
ST. VINCENT'S HOSPITAL ...	100	860	Dr. J. M. O'Ferrall Mr. K. I. O'Doherty Dr. Quinlan		For particulars, see Advertisement, page 1.
CITY OF DUBLIN HOSPITAL ...	60	582	Dr. Jacob Dr. Beatty Dr. Benson Dr. Hargrave Dr. Williams Dr. Geoghegan Mr. Tufnell		For particulars, see Advertisement, page 4.
JERVIS-STREET HOSPITAL ...	60	720	Dr. Hughes Dr. Martin	Mr. O'Reilly Mr. Ellis Dr. Stapleton Dr. Harrison Dr. Banon Dr J. S. Hughes Dr. J. H. Power	
MERCER'S HOSPITAL ...	60	622	Dr. Osborne	Mr. Tagert Dr. Jameson Dr. Bevan Mr. Butcher	

SPECIAL HOSPITALS OF DUBLIN IN WHICH CLINICAL INSTRUCTION IS GIVEN.

- SIR P. DUN'S HOSPITAL**, into which are admitted all cases requiring *medical assistance*. The Clinical Professors are the King's Professors in the School of Physic. (*See Advertisement, page 1.*)
- THE ROTUNDA LYING-IN HOSPITAL** contains 127 beds; receives 2,000 women annually; is presided over by Dr. McClintock as *Master*, with Drs. Guinness and Byrne as *Assistants*. (*See Advertisement, page 6.*)
- THE COOMBE LYING-IN HOSPITAL** contains 21 beds; receives annually 583 patients.
- THE CORK-STREET FEVER HOSPITAL** contains 120 beds; receives 2,000 patients annually. Admission is restricted to cases of *Fever*.
- ST. MARK'S OPHTHALMIC HOSPITAL**, devoted to diseases of the Eye and Ear, accommodates 20 indoor patients; and has attached to it an operating theatre and an extensive dispensary. The indoor patients are visited daily. The *Attending Surgeon*, Dr. Wilde, delivers a course of clinical instruction in the Hospital during the Winter Session. (*See Advertisement, page 3.*)
- THE LOCK HOSPITAL**, with 40 beds, is constantly occupied with cases of syphilis. Dr. T. Byrne, Surgeon.
- THE INSTITUTION FOR DISEASES OF CHILDREN**, in PITT-STREET, is attended by Drs. Hardy and Moore, and is entirely devoted to the treatment of diseases incidental to children. (*See Advertisement, page 11.*)
- THE RICHMOND DISTRICT LUNATIC ASYLUM**.—*Visiting Physicians*—Dr. Mollan, Dr. Tuohill, Dr. Banks. *Surgeon*—John Hughes, L.R.C.S.I. Contains 600 patients. A course of Lectures on Insanity and Mental Diseases is given by Dr. Banks in the Theatre of the Richmond Hospital. (*See Advertisements, page 5.*)

THE QUEEN'S UNIVERSITY IN IRELAND.
EXAMINATION FOR HONORS—M.D.

September, 1857.

MEDICINE.—Examiner, J. C. FERGUSON, A.M., M.B.

1. Enumerate the different terminations of pleuritis and their effects upon the thoracic parietes.
2. What cause is usually productive of the greatest amount of combined hypertrophy and dilatation of the heart; and what are the signs of its existence?
3. With what diseases may peritonitis be confounded, and how is its presence to be determined?
4. Prescribe a full opiate for an adult in fever; and what are the indications for its exhibition?
5. Under what circumstances is phthisis supposed to be remediable; and what the latest means proposed to effect that object?
6. Enumerate the various sources whence air is found in the cavity of the pleura, and the physical signs which accompany each.
7. Describe, in the order of their occurrence, the changes of structure produced by inflammation of the brain's substance, and the symptoms indicative of each.
8. What do you believe to be the morbid condition of the nervous centres, and of the circulation in typhoid fevers; and what the consequent indications of treatment?

SURGERY.—Examiner, MAURICE HENRY COLLIS, M.B., F.R.C.S.I.

- A. Sketch, carefully, the pathological changes in bone, from the first rise of inflammation to its termination in—
 1. Caries; 2. Necrosis; 3. Hypertrophy.
- B. What do you understand by the manipulatory mode of reducing dislocations, as proposed by Colombat, Reid, &c.; and what advantages has it over extension and counter-extension?
- C. What are the proofs of the muscularity of the urethra?

By whom were its muscular fibres demonstrated?
How are they arranged, and from whence are they derived?
- D. When, and by whom, were operations for cleft palate first performed; and what improvements have since been made by Dieffenbach, Fergusson, and Mason Warren?
- E. What division of tumors does Mr. Paget make?

What are the external characteristics of rapidly growing (soft) cancer?
What is the least unfavourable form of cancerous tumor for removal? Give your reasons.

ANATOMY AND PHYSIOLOGY.—Examiner, ROBERT HARRISON, M.D., Professor of Anatomy, T.C.D.

1. In the development of the vertebrata, symmetry as to form and size, on the right and left sides of the median line, or spinal column, is the prevailing rule; can you state any remarkable exceptions?
2. Contrast the bones in the limbs of the elephant, the pig, and the horse.
3. Mention the principal peculiarities in the skeleton of the bird.
4. Describe the phenomena observed during the coagulation of the blood.
5. Mention some reasons in support of Mr. Hunter's opinion, that "the coagulation of the blood is an operation of life," or a process of organization.
6. Explain the appearance of inflammatory blood, and the cause of the "Buffy coat."
7. Contrast the red and white globules of the blood.
8. Do the globules present any peculiar appearance in inflammatory blood, or do they appear to have any influence in forming the buffy coat?
9. What is the form of the red corpuscles in mammalia, aves, reptilia, and pisces?

10. State the general character of the blood corpuscles in the invertebrata.

11. Describe the peculiar arrangements for the circulation of the blood in the fœtus in utero.

12. Describe the situation, the boundaries, and all the relations of the femoral or crural ring or canal; also, state the use or design of this passage, and contrast its appearance in the child, in the adult male and female.

ANATOMY AND PHYSIOLOGY.—Examiner, ROBERT HARRISON, M.D., Professor of Anatomy, T.C.D.

1. The peculiar colour of the hæmatine in the red corpuscles of the blood has been supposed to depend on the iron it contains: has this been denied; if so, by whom, and on what grounds.
2. The change of colour in the blood during respiration has been ascribed to a change in the state of the iron in the hæmatine produced by the contact of gases with the blood; how has this opinion been refuted, and to what other cause has this change in colour been attributed?
3. Describe the course, and mention all the relations of the left common carotid artery, from its origin to its division.
4. Mention the structure of "muscle," and the microscopical appearance of the "fibre."
5. Contractibility of muscle is by some considered a "vis insita;" by others, a "vis nervosa." Which of these opinions is most generally approved of at the present time? and state the reasons why it is so.
6. Describe the arterial inosculation in the mesocolon from one iliac region to another.
7. Mention the principal differences between the cheiroptera and the aves, both structural and functional.
8. Describe the process of dentition in the elephant; and state the differences between the teeth (proper) and the tusks.
9. Describe the course and relations of the external iliac artery.
10. Describe the digastric muscle, its relations and actions.

CHEMISTRY.—Examiner, THOS. H. ROWNY, Ph.D.

1. Give the test for strychnine.
2. Describe Reinsch's test for the detection of arsenic.
3. Give the general characters of albumen, and show how it may be detected both in acid and alkaline urine.
4. Give a short description of the constitution, properties, and uses of the atmosphere.
5. What change does benzoic acid undergo in passing through the human system?
6. Describe the preparation and properties of chloroform.
7. Give the different views of the constitution of alcohol and ether.
8. Give an explanation and some examples of catalysis.
9. What is the constitution of the salts called alums?
10. Describe the process for preparing Scheele's hydriodic acid.
11. Give the tests for sugar in diabetic urine.
12. Give Graham's law for the diffusion of gases.
13. Explain the terms, Metameric, Polymeric, and Isomeric.
14. What is meant by a compound radical? Give some examples.

MIDWIFERY AND DISEASES OF WOMEN AND CHILDREN.
Examiner, DR. HARVEY.

1. Give the anatomical and physical conditions observed in the generative organs of mammiferous animals during the time of heat or rut; and the points of agreement or difference between these and the phenomena accompanying menstruation in the human female.
2. Describe the various conditions as to extent, situation, structure, and general relations under which

the ovary is found to exist in the different orders of vertebrated animals. Are the same component structures to be found throughout the series?

3. Contrast the well-formed female pelvis with the variety known as the "masculine pelvis;" and also with that in which development has been arrested. How would you expect labour to be modified by each of these conditions?

4. State the symptoms, early and late; progress, termination, and pathology, of uterine hydatids. What treatment may be required towards the end?

5. A young woman, hitherto healthy, has been suffering for some months from headache, with monthly aggravations. There is a distinct ovoid abdominal tumor occupying the hypogastrium, which has been gradually increasing, and the breasts are fuller than formerly. It is stated that she has never "been unwell," but pregnancy, notwithstanding, is suspected. How would you proceed to determine the question, and what view do you take of the case?

6. How does the allantois originate? To what class of membranes would you refer it? What purposes does it serve in birds, and what in the mammalia?

7. A woman has just been delivered, after a rather severe labour, which has left a well-marked "caput succedaneum" on the head of the child; and the secundines have been preserved uninjured. From these data can you determine the position and progress of the child in the labour; and the situation of the placenta; and how?

8. Describe the most usual mode of aggression of puerperal mania. What is the prognosis, as compared with that of mania arising under other circumstances? What should be the general character of the bodily treatment in this disease?

9. What are the principal points of evidence that a woman has been delivered of a child; and that she has been recently delivered?

10. State, in outline, the circumstances under which ergot is indicated in uterine hæmorrhage; and those under which opium is required. Is there any general rule affecting the dose of opium borne in these cases?

11. In accordance with what general law affecting eruptive febrile diseases, does cow-pox protect the system from the attacks of small-pox? Are you aware of any series of experiments which prove that the law in question applies as strongly to this case as to that of eruptive diseases generally?

12. What is the pathology of puerperal convulsions, according to the latest investigations?

MATERIA MEDICA AND PHARMACY, AND MEDICAL JURISPRUDENCE.—Examiner, Dr. GROGHEGAN, Prof. R.C.S.I.

1. How is chloroform prepared? State its composition and chief properties, the density of its vapour, the tests of its purity, and the precautions to be observed in its administration.

2. Enumerate the causes of pseudo-morbid appearances in the dead body, and give an illustration of the action of each.

3. If appearances of latent disease of a serious kind should be discovered in the body of a person who had been the subject of violence shortly before death, what inquiries would you institute in order to determine which of these causes had produced the fatal result?

4. Describe, concisely, the processes of levigation, elutriation, and percolation by displacement, and state the advantages and defects of the latter.

5. Enumerate the proximate principles peculiar to opium (distinguishing the basic from the neutral), and those which are common to it and to other vegetable juices, and describe the physical and chemical properties of Morphia, and of Meconic acid.

6. What quantities of the carbonates and bi-carbonates of potass and soda, and of the sesqui and bi-carbonate of ammonia, are severally necessary to saturate

half an ounce of lemon juice (about 16 grains of citric acid)?

7. Describe and explain the process by which "Antimonii sulphuretum precipitatum" (D.P.) is obtained, and state how it differs from *Kermes mineral* and from "Antimonii sulphuretum preparatum."

8. What is the weight, avoirdupois, of 3 fluid oz. of rectified spirits, sp. gr. 0.840 (fluid oz. of dist. water = 437.5 grs.) and what the fluid measure of 2 oz. avoirdupois, of nitric acid, sp. gr. 1.500.

9. Contrast the phenomena of strychnia-poisoning in the human subject, with those of traumatic tetanus, and describe the ordinary and exceptional *post-mortem* appearances of the former, both external and internal.

10. Describe the methods of Reinsch, Davy and Marsh, for the detection of arsenic, and state the rationale of each.

11. Describe and explain the process by which Pulvis Antimonialis (D.P.) is prepared, and state the precise composition of James's Powder.

12. Enumerate the modes of applying frictional and galvanic electricity for medical purposes, and state briefly their relative advantages and defects.

BOTANY.—Examiner, Professor W. SMITH, F.L.S.

1. Give the homologies of the different parts of the floral gynæcium, with reasons for your statements.

2. Explain the meaning of the signs $\frac{3}{4}$, $\frac{4}{5}$, and $\frac{5}{6}$; and show to what classes of plants they are ordinarily applicable.

3. Define the following terms:—Anatropus, orthotropus, campylotropus; and give illustrations of their use in reference to plants of the British Flora.

4. Refer the plants before you to their natural orders, give your reasons for doing so, and add brief specific descriptions of each.

ZOOLOGY.

1. To what order in aves would you refer the extinct Dodo, and on what grounds?

2. What points in the history of the tapeworm are now established, and what are still matters of uncertainty?

3. Point out some of the special modifications of the eye in the invertebrate animals, with the reasons of such modifications.

4. Mention some animal products that are employed in medicine, with the names of the animals supplying them.

NATURAL PHILOSOPHY.—Examiner, JOHN STEVELLY, LL.D.

1. Two spheres whose radii are respectively r and r' and their weights are w and w' , are placed in contact; find their common centre of gravity.

2. The launching ways of a ship have an inclination of one foot in sixteen; what force should be exerted upwards, parallel to the ways, to prevent a ship of nine hundred tons from sliding down?

3. A ship sails along her course at the rate of ten British miles per hour; find how many feet she moves over each second, and explain why a person who leaps up from her deck is not left that distance behind, if he be a second without any support from the vessel.

4. What remarkable relation is there between the spaces described in successive equal intervals of time by a body moving from rest under the influence of a uniform accelerating force?

5. Two fluids whose specific gravities are ρ and ρ' and which have the volumes v and v' , are mixed, and the volume of the mixture is found to be diminished by $\frac{1}{10}$ th parts of the original volumes; what is the specific gravity of the mixture?

6. Give an account of the different methods which have been employed to measure the temperatures superior to the boiling point of mercury.

7. Describe the method of obtaining the density of vapours.

8. Describe the electrical condenser, and investigate the limit of the condensation which its collecting plate can effect.

9. The fundamental formula of Ohm's Theorem is $f = \frac{E}{R+r}$; explain this formula, and illustrate its application to one or two simple cases of voltaic combination.

10. Why are not the changes of temperature which take place in the pulses during the propagation of sound, from the alternate condensation and rarefaction of the air, observable by the thermometer?

11. Explain the distinction between left-handed and right-handed circular polarization, and by what observation substances possessing each are distinguished.

12. How has this property, as possessed by certain liquids, been turned to practical account in some of the arts?

13. Explain the optical contrivance by which the lenticular stereoscope is made to unite the corresponding points of the two pictures in the single image, as seen through the instrument.

14. Explain the distinction between homogeneous and compound light, and the discovery of Newton of the composition of solar light.

15. Describe the manner in which Sir David Brewster considers the solar spectrum to be composed, and the method of analysis of solar light resorted to by him.

MODERN LANGUAGES.—EXAMINER, PROFESSOR DE VERICOUR.

Translate a given passage from French (*Lallemand*), into English.

1. Explain the following expressions: *tumeurs à couches concentriques*; *noyau graveleux*, *blanchâtre*; *nodosités osseuses*; *les ventricules regorgeaient de sérosité*.

2. Give the various significations of the words *graveleux*, *taillé*, *esprit*.

3. Mention some of the words and expressions which have been taken from the French in the English medical language.

4. Give the rules of French grammar on the past participle, with examples.

5. Say what you know of Ambroise Paré.

Translate a given passage from a German Author.

1. On which of the syllables does the accent regularly fall in German?

2. What is the sign of the past participle in German, and when is it omitted?

3. Name the most celebrated works of Schiller.

4. Give the signification and etymology of the following words: *mager*, *blass*, *hettish*, *Athem*, *hab*, *Stich*.

5. Compare the German language with the Greek, with reference to the faculty of forming compound words. Give numerous examples in both languages.

Translate a given passage from Italian (*Beccaria*) into English.

1. Translate and explain *fatto ch' ebbe*; *parlato ch' ebbe*.

2. Give the present of the indicative of *udire*.

3. Explain the difference between *furono*, *errano*, and *erano*.

4. Give the present indicative and preterite of *volgere* and *volere*.

5. Explain the general character and derivation of the Italian technical terms in medical science. Give numerous examples, and comparisons with those in French and English which are totally dissimilar in their origin or etymology.

Translate into French, German, or Italian, a given passage from *Dr. Laycock's lectures*.

APPOINTMENTS.

Dr. James E. Sawyer, one of the Masters of the Coombe Lying-in Hospital, has been appointed Professor of Midwifery to the Royal College of Surgeons in Ireland, in the room of Dr. Beatty, resigned.

Dr. J. A. Byrne, 26, Westland-row, has been elected Assistant Resident Physician to the Lying-in Hospital, Rutland-square.

Dr. Lyons and Dr. A. McDonnell, have been respectively elected Physician and Surgeon to Jervis-street Hospital, in the room of Dr. Martin and Dr. Harrison, resigned.

THE ARMY.

WAR OFFICE, PALM-MALL, OCTOBER 16.

Royal Artillery.—Assistant Surgeon Henry Bowles Franklyn, from the Staff, to be Assistant Surgeon, vice Rudge, promoted to be Staff Surgeon of the Second Class.

HOSPITAL STAFF.

Deputy Inspector General of Hospitals William Linton, M.D., C.B., from half-pay, to be Inspector General of Hospitals with local rank in India.

Staff Surgeon of the First Class Frederic Roberts, from half-pay, to be Staff Surgeon of the First Class.

To be Staff Surgeons of the Second Class.—Assistant Surgeon T. Ramonde White, M.D., from the 68th; Assistant Surgeon Alexander George Montgomery, from the 48th foot; Assistant Staff Surgeon Henry Frederic Robertson; Assistant Surgeon William Singleton, M.D., from the Cape Mounted Riflemen; Assistant Surgeon Brinsley Nicholson, M.D., from the 60th Foot; Assistant Surgeon James William Fleming, from the 37th foot; Assistant Surgeon Joseph Thomas La Presle, from the 84th Foot; Assistant Staff Surgeon Gordon Keamure Hardy, M.D.; Assistant Surgeon Edw. Dawson Allinson, from the Royal Artillery; Assistant Surgeon Henry Fisher, from the Royal Artillery; Assistant Surgeon Arthur Stewart Willocks, from the 78th Foot; Assistant Surgeon Henry Highte Jones, M.D., from the 37th foot; Assistant Surgeon Edward Wm. Clemens Kingdom, M.D., from the Royal Canadian Rifle Regiment; Assistant Staff Surgeon James Lewis Holloway; Assistant Surgeon James Kells, M.D., from the 86th Foot; Assistant Staff Surgeon Frederick Clarke; Assistant Surgeon David Field Rennie, M.D., from the Royal Artillery; Assistant Staff Surgeon James Edmund Clatterbuck, M.D.; Assistant Surgeon Grahame Auchincloss, M.D., from the 81st Foot; Assistant Surgeon Henry Martyr Fraser, M.D., from the 16th Foot; Assistant Surgeon George William Peake, M.D., from the 46th Foot; Assistant Surgeon John Henry Halahan, M.D., from the Royal Artillery; Assistant Surgeon Arthur Rudge, from the Royal Artillery; Assistant Surgeon Edward Touch, M.D., from the 53rd Foot; Assistant Staff Surgeon John Irvine, M.D.

To be Assistant Surgeons to the Forces.—Robert Walter Cliffe, Gent. vice Peacocke, appointed to the 74th Foot; Edward Frank Harris, Gent. vice Hungerford, appointed to the 53rd Foot; Deimus Hodgson, M.D., vice Hollingsworth, appointed to the 8th Foot; William Alexander, Gent. vice Harris, appointed to the 32nd Foot; John M'Lechle, Gent. vice Beale, appointed to the 53rd Foot; David Shorter Skinner, Gent. vice Magrath, appointed to the 54th Foot; Frederick William Wade, Gent. vice Fuller, appointed to the 9th Light Dragoons; Charles M'Kinnon, Gent. vice Lower, appointed to the Royal Artillery.

WAR OFFICE, PALM-MALL, OCTOBER 23.

HOSPITAL STAFF.

Surgeon Peter Henry Rowe, from the Gold Coast Artillery Corps, to be Staff Surgeon of the First Class.

To be Assistant Surgeons to the Forces.—Wm. Alexander Mackinnon, late Assistant Surgeon, 42nd Foot; Oswald Home Bell, M.D., vice Read, appointed to the Royal Artillery; Geo. Whittle, Gent. vice McGill, appointed to the 7th Dragoons Guards; Robert Heard, M.D., vice Rudd, appointed to the 8th Light Dragoons; Alexander Neil, Gent. vice Gibb, appointed to the 1st Dragoons; Eugene McShane, Gent. vice Clery, appointed to the 17th Light Dragoons; Joseph Marmaduke Taylor, Gent. vice Porteous, appointed to the 1st Foot; Joseph Richard Kehoe, Gent. vice F. Folliot, appointed to the 18th Foot; Henry Carden Herbert, Gent. vice J. Folliot, appointed to the 51st Foot; Edward L'Estrange, M.D., vice Barnack, appointed to the 34th Foot; Augustin Oliver Applin, Gent. vice Collie, appointed to the 98th Foot; James Good, Gent. vice Hyde, appointed to the 18th Foot; John Henderson Whitaker, Gent. vice Robertson, promoted on the Staff; Thomas Liddard, Gent. vice Hardie, promoted on the Staff.

COMMUNICATIONS have been received from Dr. McCormac, Belfast (with enclosure on Insanity); Dr. Lister; Mr. Hennessey; Dr. Morgan; Dr. Moore; Dr. Banks; Dr. Stokes; Mr. Petheram; Dr. Beale; Dr. O'Donovan (with enclosure); Mr. Farrell; Dr. Haughton.

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INTRODUCTORY LECTURE

DELIVERED AT THE

LYING-IN-HOSPITAL, RUTLAND-SQUARE,

November 8, 1857,

By ALFRED H. MCCLINTOCK,

M.D., F.R.C.S.L., L.R. & Q.C.P., M.R.I.A., &c., &c.

Master of the Hospital.

(Abridged for the DUBLIN HOSPITAL GAZETTE.)

GENTLEMEN—You are all aware that the healing art has been divided into three branches or sections, viz.:—Physic, Surgery, and Obstetrics. This last embraces the anatomy, physiology and pathology of the female reproductive organs, together with the medical and surgical treatment of their diseases.

Of late years this department of medicine has expanded into such vast proportions, and has become of so great consequence, that in all our cities and large towns are men who practise it exclusively, or make it, at all events, their principal pursuit. Besides this, the importance of obstetric knowledge is now becoming more and more generally felt and recognised. Of this growing importance we see around us many satisfactory proofs. The King and Queen's College of Physicians, and the Royal College of Surgeons in England, have, wisely I think, followed the example set them by the Royal College of Surgeons, Ireland, seventy-two years ago, in establishing a separate examination in midwifery for such of their licentiates as desire to give evidence of possessing a more than ordinary acquaintance with this subject. The Edinburgh College of Surgeons, too, has within the last year or two made practical midwifery a part of its curriculum.

The public medical services, also, are beginning to be impressed with the same views, and now require that the candidates for their patronage shall give undoubted proof, not merely of having had the opportunity of studying midwifery, but (and I beg your attention to this) of having profited by these opportunities, and of having acquired a good prac-

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tical knowledge of obstetrics. Of all branches of the public medical service, the naval is perhaps that in which an acquaintance with midwifery would seem most dispensable; and yet I am informed that midwifery now forms a part—and no inconsiderable one either—of the subjects of examination before the Naval Medical Board, and is the one of which candidates are beginning to be most afraid. I may further mention—in order just to show what great weight is now attached to obstetric knowledge, and what encouragement there is for its acquisition—that quite recently, in the selection of an assistant colonial surgeon for the Cape of Good Hope, the Government determined that proficiency in this department of medical science should be the primary qualification. On this ground, application was made to me—as Master of this hospital—by the Secretary for the Colonies, the Right Hon. Mr. Labouchere, to send forward the name of a surgeon whom I could recommend as a well qualified accoucheur. It gives me much pleasure to add that without hesitation I sent in the name of Mr. Chas. Egan, who obtained my special certificate some months ago, and who is doubtless known to all of you as the successful competitor for the Pathological Society's gold medal, the year before last.

His great zeal and diligence in the wards of this hospital, together with native talent of no ordinary kind, have thus, I am happy to say, obtained for him an honourable and lucrative position at the very outset of his medical career.

To many amongst you Midwifery is quite a new subject, and you are only just entering upon its study. A lying-in-hospital differs so essentially from any other description of hospital, that I feel it a duty to lay down certain ethical rules for your observance whilst attending here. This I do the more readily, because these precepts do not merely apply to your conduct when frequenting our wards—no, they must also be followed out in private practice, and be consistently adhered to in your attendance upon lying-in women, whatever may be their rank or class in society.

1. In the first place, then, never for a single moment forget that these patients, one and all, belong

to the weaker sex, and that you see them under their sorest trial, and at the time of their greatest bodily suffering. In common with all other sufferers, they claim *humanity and gentleness* at your hands. But this is not sufficient: you must also exercise towards them the utmost *forbearance and delicacy*. In the extremity of her anguish, the parturient woman will sometimes utter expressions of impatience or of reproach, which she is unconscious of, or cannot control. She may be restless or refractory, setting at naught your advice and disregarding plain injunctions.

On all such occasions you must make the necessary allowance for the patient; and instead of minding her intractable behaviour, you should redouble your efforts to diminish her sufferings and to sustain her flagging energies.

Never allow yourselves to be betrayed into using a harsh word or rude act towards the patient. It might apparently escape notice at the moment, but most assuredly it would not be forgotten. Prolonged pain and deferred hope are trying to the temper, even of those who have the best regulated minds. No wonder, then, if irritability or petulance should be evinced by some of our patients; we should rather regard it as one of the physiological manifestations connected with parturition. By accustoming our minds to this way of thinking we shall the better preserve that equanimity and self-possession so requisite in the puerperal chamber.

Now this is your proper course, irrespective of all consequences; but I can assure you, such a line of conduct will bring its own reward.

2. Not less incumbent upon you is it, that your ministrations upon the *accouchée* shall be marked by *delicacy*, both in word and deed. Everything that would needlessly hurt or offend the feelings of our patient must be *studiously avoided*. In acting so we fulfil a sacred duty. Ocular and manual examinations have to be made in the course of labour, which are of necessity irksome and disagreeable; but on the faith of their being absolutely requisite for the benefit and preservation of herself and offspring, no sensible, right-minded woman, after being so informed, raises any objection to these inquiries being instituted. You must be careful therefore, to remember and to act upon this tacit understanding. He who disregards it inflicts an uncalled-for wound upon female delicacy, and is guilty of a breach of faith towards his patient.

I am perfectly satisfied that by habitually consulting the feelings of your patients, and respecting the claims of delicacy on all possible occasions, you shall grow in their confidence and estimation—thereby showing, in one of many instances that might be adduced, how the path of moral duty and of self-interest entirely coincide.

3. A third precept there is which I would earnestly beg of you to remember, when engaged in the practice of midwifery here or elsewhere, and it is this, *never to go to a case of labour without previous careful ablution of your hands, and changing your*

clothes if you have been about a patient with erysipelas, diffuse inflammation, or fever of any kind whatsoever. Many of you, I know, take out anatomical tickets and hospital practice at the same time you attend here. I am aware that this is unavoidable, but I wish it were otherwise; and I am very sure you would find it greatly to your own advantage to study midwifery by itself, that is, when you are not occupied with these studies which necessarily engross so large a proportion of time.

The reason for the above precautions is based on the facts that puerperal fever is capable of being produced by inoculation with the minute particles of matter conveyed on the fingers or hands of the accoucheur from wounds, ulcers, abscesses, erysipelatous sores, or from autopsies. That this is more than a bare probability was proved on a large scale a few years ago, by Dr. Semelweis, in the great lying-in hospital of Vienna, where upwards of 200 women are delivered monthly.

Experience has also shown that this terrible malady, puerperal fever, may be induced by contagion or infection, carried to the lying-in woman in the clothes of the attendant, from patients labouring under the diseases already mentioned, namely erysipelas, diffuse inflammation, pyæmia in every form, and malignant fevers of different kinds.

Now, if it be a matter of importance—of moral obligation—to use these precautions in private practice, where a single patient is the object of your care, surely it becomes doubly, trebly incumbent upon you to do so in hospital practice, where you will be in contact with two, three, four or perhaps more lying-in women.

4. There remains one other caution which I think it expedient to lay down for your guidance in the puerperal chamber. *You should keep a strict guard on your conversation, manner, and expression towards the patient, and within her hearing, so that she may not, through you or from you, come at the knowledge of any fact or opinion which might depress or disturb her mind.*

This is, without doubt, a golden rule of obstetrical ethics, and should never be forgotten in all our intercourse with puerperal patients. But it is not every man who possesses this habitual caution and reserve; a few indeed have it by nature, but with most of us it has to be acquired by careful discipline and mental training. It is, without doubt, desirable that the physician should at all times exercise this caution and self-command in the sick room; but these qualities are pre-eminently necessary in his attendance upon women in child-bed. Wanting them, the accoucheur, no matter how proficient he may be in the knowledge of his art, can scarcely be considered competent to practise it with success. I have sometimes been distressed beyond measure at observing the immediate ill effects produced by an indiscreet remark, an unfavourable opinion, or a grave prognosis, uttered in the hearing of a patient, at a time when her life seemed

trembling in the balance. It is seldom you will be able by any process of reasoning to remove the unfavorable impression which the unguarded look or word has made. "*Verbum semel emissum volat irrevocabile.*"

The reason for such excessive caution is to be found in the condition of the nervous system in this class of patients. This condition is one in which the nervous system attains the utmost degree of activity, short of actual disease—the higher organic functions seeming to be more directly and immediately under the influence of the sensorium than at any other time. This exalted nervous susceptibility "displays itself under a great variety of forms and circumstances, rendering the female much more excitable and more easily affected by external agencies, especially those which suddenly produce strong mental or moral emotions, whether of the exhilarating or depressing kind, as fear, joy, sorrow, anger. The powerful influence of such impressions over the functions and actions of the uterus, in every stage of female life after puberty, is recognized in a multiplicity of circumstances, whether as deranging menstruation, inducing abortion, modifying the energy of parturient action, or in affecting the recovery from childbed." (Montgomery, p. 17.)

This increased nervous sensibility, you perceive, characterizes the entire period of utero-gestation, but reaches its culminating point during parturition and the succeeding few days.

There are many remarkable cases on record, exhibiting the bad or fatal consequences which may ensue from sudden emotions, or strong mental impressions during pregnancy and childbed. The earliest recorded illustration, and a very striking one, moreover, is contained in the first book of Samuel, where we are told, in the simple but graphic language of inspiration, that when Eli's daughter-in-law, who was with child, near to be delivered, "heard the tidings that the ark of God was taken and that her father-in-law and her husband were dead, she bowed herself and travailed, for her pains came upon her. And about the time of her death the women that stood by her said unto her, Fear not, for thou hast borne a son; but she answered not, neither did she regard it." (iv. 19, 20.)

Dr. Merriman narrates a very singular case where a fatal convulsive attack seized a woman in labour, in consequence of the unexpected entrance into her chamber of a person towards whom she entertained a strong aversion. This same respectable authority tells us that the lamented death of the Princess Charlotte, years after the event, was found to operate unfavourably on patients of a certain rank in life.

It was long ago remarked by Dr. John Clarke—a most accurate observer—that unmarried women were peculiarly obnoxious to the attacks of puerperal fever. My own experience fully and entirely corroborates this. I moreover think, that amongst this unfortunate class of patients, puerperal mania

and puerperal convulsions occur in larger proportion, whilst the mortality arising from the immediate consequences of childbed is far greater than among married women. All this very forcibly shows us, I think, what strong influence the nervous system exerts over all the functions and processes of the body during the period of childbed.

Some instructive examples are related by Dr. Montgomery of this great impressibility of the nervous system; I have myself seen many instances, both in hospital and private practice, but those already given will suffice to illustrate the remarks I have made.

Having thus briefly considered the principal circumstances of conduct and manner, that specially and peculiarly need to be borne in mind in our attendance upon midwifery patients, let me draw towards a conclusion.

To see and examine, under correction, a large number of labour cases, even though you should not conduct the delivery in any of them, is of first-rate importance towards forming a good practitioner.

Before the establishment of Lying-in-Hospitals, the great mass of students had, I may almost say, no means of acquiring a practical knowledge of midwifery, or of studying it clinically. Smellie, one of the greatest among British accoucheurs, was for many years an eminent teacher of midwifery in London. He instructed altogether about 1000 pupils, and gave upwards of 280 courses of midwifery, during the middle of the last century. Each pupil, during his attendance upon two of these courses, witnessed *four* cases of labour, and conducted *one*; and with this amount of clinical experience he started upon practice! No wonder if good accoucheurs were scarce in those days. But it is even possible for a pupil to attend a large number of cases and to profit little from them, where he is not under the guidance of a competent instructor. On this point a recent writer in a Scotch periodical, who speaks from experience and with the air of an authority, thus expresses himself: "It is well known that the medical student of Glasgow, however well he may be versed in the theory of midwifery, is, in most instances, but a poor hand at its practice, even after having attended a number of cases. The reason is obvious, for he attends the patients at their own houses, receives no practical instruction, and no direction throughout the whole of them. *And it is a notorious fact, that many in consequence, although they have attended cases for some months, are quite unable to discover the os uteri*; and it need hardly be said (he continues) that the 'tactus eruditus' in finding it is the first thing the obstetrician has practically to learn, the very groundwork on which all the rest is built."

Well may the students of later years venerate the memory of that distinguished medical philanthropist who conceived the design of establishing an hospital specially for lying-in patients, and who

was the first in the British dominions to carry this noble design into execution. You will, I am sure, excuse me if I make an episode here upon a subject which has thus come incidentally under notice.

The establishment of this hospital, now upwards of 112 years ago, is inseparably connected with the name of Surgeon Bartholomew Mosse, and with the rise of the Dublin School of Midwifery. Within a few days will come round the *hundredth anniversary* of the opening of the present edifice for the reception of patients. Surely then the occasion is one which specially invites me, not merely to offer a passing tribute to the memory of Mosse, but to lay before you a brief sketch of his life and acts, which in truth constitute his highest eulogy.

Bartholomew Mosse, son of the Rev. Thomas Mosse, Rector of Maryboro', in the Queen's County, was born in the year 1712. He served an apprenticeship to Surgeon John Stone of this city, and received a qualification or licence to practice in 1733, from the Surgeon-General of the day. The College of Surgeons was not incorporated for many years after this, namely, till 1784, prior to which event it would appear that the Surgeon-General had a power to examine and grant licences in surgery. He also obtained from the College of Physicians in 1742, their licence to practice the art of midwifery. Mosse being desirous of improving himself in surgery and midwifery, travelled into England, France, and Holland, and several other parts of Europe. In this tour he paid particular attention to the hospitals of the countries through which he travelled, as before his departure from home he had become convinced of the great usefulness, if not necessity, of having an hospital for lying-in women in this city, and even at his early period of his career, had resolved, as far as lay in his power, to have such an hospital established.

The circumstances which most strongly led him to believe in the existence of this necessity, were—1stly, The privations and miseries endured by the women of the humbler classes, especially among tradesmen, during the time of childbirth; and 2ndly, The insuperable difficulties that existed to the acquisition of obstetric knowledge in this country, insomuch that medical men were obliged to resort to some of the Continental schools to learn midwifery.

Having matured his plans, he took a large house in South George's-street (or George's-lane as it was then called); furnished it with beds and other requisites; and opened it for the reception of patients on the 15th March, 1745. "The house which he purchased in George's-lane, is at present No. 59, South Great George's-street, opposite Fade-street; it stands back from the street, and is now approached by a narrow alley; the first building contains twelve rooms with closets for nurses; and at the rear of this is a second, containing one large and two small wards, with out-offices. In front of this there was originally a court-yard,

which may still be seen on some of the old maps of the city, but this space has long since been filled up with buildings; the whole is now in a most dilapidated condition, and tenanted by a number of poor families."—(*Wilde, in Dublin Journal, Nov., 1846*).

The hospital in George's-lane was established, you will observe, and for a considerable time maintained, entirely by Mosse himself; subsequently, however, as the charity began to be known and appreciated, voluntary contributions came in; besides this source of income he obtained some money by concerts, oratorios and lotteries, which he himself planned, and the expense and risk of which he solely sustained.

This continued to be the hospital till the 8th December, 1757, when the present building was opened, and the patients were transferred thereto from George's-lane. During this period of twelve years, 3,975 women were delivered in the old hospital of 4,049 children, 74 of the women having given birth to twins. A very careful registry, which is still preserved, was kept of all these cases. In a report of the hospital published by Mosse in 1755, he gives a statistical account of all the women admitted from its first opening in March, 1745, to September, 1755; with their different ages, their residences, the class of society to which they belonged, the number of deliveries, results, and sex of children, and the mortalities of mothers and children, together with the number of twins, "forming," to quote the words of his biographer, Mr. Wilde, "altogether one of the most interesting as well as the earliest statistical tables of this description on record, and showing that the registry of this hospital, a hundred years ago, was better kept than many at the present day."

About two years after establishing the hospital, reports of its success reached the other side of the channel, and raised a desire in the minds of some well-disposed persons to open a similar institution in London, which was as yet unprovided with any hospital of the kind. Application was accordingly made to Mosse for his plans and regulations, &c., which he cheerfully transmitted, and the result was the establishment of the Brownlow-street (now Endell-street) Lying-in-Hospital in 1749, which was followed in the course of the next five years by the British, the City of London, and Queen Charlotte's Lying-in-Hospitals.

Finding the accommodation of the house in George's-lane inadequate to meet the demands for admission, Mosse formed the bold resolution of erecting a commodious hospital in some suitable locality. With this object he bought, in August, 1748, the piece of ground now occupied by the hospital, public rooms, and Rotunda Gardens; and shortly afterwards expended upon it a sum of about £2,000.

Having purchased a quantity of timber and other materials towards erecting the new hospital, he caused the first stone to be laid by the Lord

Mayor on the 4th June, 1751, at the south-west corner of the building. This ceremony was conducted with all the pomp and formality befitting the occasion; and doubtless every one present supposed that Mosse had the promise of ample means to carry on the work—the real fact being, that on the morning when the first stone was laid, he was barely worth £500; and although he knew the hospital must cost over £20,000, yet he never despaired of seeing it finished, and never relaxed in his exertions. Mosse was too well read in human nature, and too deeply interested for the success of his philanthropic enterprise, to let his poverty be known at this critical juncture.

For the next six years the old hospital had to be maintained, and the building of the new one to be carried on, all which required, as you may well suppose, a vast deal of money. However, Mosse was just the man to grapple with and to overcome the difficulties which opposed themselves at every step of his enterprise.

Not only had he suffered at this time in pocket, but in character. Our great dramatist has said, "Be thou as chaste as ice, as pure as snow, thou shalt not escape calumny;" and so it proved with Mosse. It was reported that in all he had done he was actuated only by the most sordid motives, and that under the pretext of charity he was extorting large sums of money, which he would put into his own pocket, and then at the first convenient moment abscond! So far only as he himself was concerned, these rumours were but as idle words. But he well knew it would not serve the great object to which he consecrated his time, his talents, and his money, to leave these slanders uncontradicted. He therefore at once adopted the most effectual means to silence his traducers. He executed a declaration of trust, whereby he made over this property to three gentlemen of note, in trust for the use and support of the lying-in-hospital.

Up to the end of the year 1755 he had managed to obtain nearly £12,000, with which he kept the old hospital in active operation, and carried on the building of the new. This large sum was partly subscribed, but was mainly realized from plays, concerts, oratorios, and "schemes" of various kinds, devised and conducted by Mosse himself. This shows us the enterprising turn of his mind, and the versatility of his genius, that in pursuits so foreign to his calling he should have proved himself such an adept.

"At this period," (I quote again from Mr. Wilde's memoir), "all his resources seem to have been exhausted; he was moreover involved in debt, and hourly subject to arrest and imprisonment, having sold or mortgaged almost everything he was worth. In this distressed condition he communicated his unhappy situation to some persons of the first rank, and was encouraged to make an application to the House of Commons, and to pray their aid to pay off the debt he had contracted

on account of the hospital, and to enable him to finish the same."

In accordance with this advice he petitioned Parliament, and obtained a grant of £6000, to be expended in defraying such debts as were then due, and to go towards finishing the work. This occurred in March, 1756. Towards the close of the same year he succeeded in getting what he had long sought for—a royal charter of incorporation for the institution. This was conferred by George II. and bears date the 2nd December, 1756. I may remark here that no other institution of the same kind in the British dominions is established as this is, under royal charter.

In the course of the year 1757 the new corporation of the "Governors and Guardians of the Lying-in Hospital" again implored the aid of Parliament to carry on the work, and recommended Dr. Mosse to the consideration of the house, briefly stating his eminent services, and the pecuniary distress to which he had reduced himself, in his devotion to the cause of the charity. In consequence of this petition a further grant of £6000 was made for the use of the hospital, and £2000 to Dr. Mosse as a reward for his exertions. After Mosse's death an additional grant of £1000 was voted for the use of his widow and children, in recognition of the sacrifices both of time and money, which he had made in establishing the hospital.

Towards the close of this year, 1757, the hospital being then nearly finished, the wards on the upper corridor were furnished and prepared for use, and on the 8th December the institution was formally opened for the reception of patients. The Lord Lieutenant and a number of the nobility and gentry were entertained at breakfast in the hospital, after which "fifty poor women," we are told, "great with child, attended in the hall with proper certificates of admission, and were all decently clothed in uniform at the expense of the hospital, each in a blue calimanco gown and petticoat, shift, handkerchief, cap and apron; and thus they appeared before his grace the Duke of Bedford, as President of the Hospital, the Duchess, and the rest of the governors and guardians, with many of the nobility and gentry, who all expressed the highest satisfaction."

Just picture to yourselves a large assemblage of ladies and gentlemen from among the highest circles of nobility and gentry, being entertained with the spectacle of "fifty poor women great with child!" And yet such was the scene enacted within these four walls 100 years ago, and at which all present expressed "the highest satisfaction." I suppose the history of the world does not supply another instance of such an exhibition to an aristocratic company. An idea so purely novel and unprecedented could only have emanated from the original mind of Mosse; and no other man could possibly have carried it into effect without offending good taste, and making a headlong descent from the sublime to the ridiculous!

Thus Mosse had the supreme gratification of seeing the hospital opened. The toils, the anxieties of many years were at length rewarded. The object of his highest ambition had now been obtained; but he was not destined long to enjoy this happiness.

The effects of protracted mental and bodily fatigue began to show themselves; now that the urgent stimulus to exertion was withdrawn. Symptoms of serious disease appeared within twelve months from the opening of the hospital, and on the 16th February, 1759, Bartholomew Mosse expired, in the 47th year of his age.

Such, gentlemen, is an imperfect sketch of the man who, undismayed by difficulties, unmoved by slander, and undeterred by want of means, resolutely prosecuted his great design of founding "an institution capable of freely receiving within its walls all who might apply, having poverty for their plea, and the pains of approaching childbirth as the grounds of their request."

May we not well feel proud to claim him as belonging to our country and to our common profession? Larger hospitals have been founded by private endowment, I freely and gladly admit; but I challenge the world to produce another instance where an hospital of the same extent and utility, has been established by the genius and zeal of a private individual, unpossessed of fortune, influence, or patronage—an institution which has now been tested by the experience of 112 years—has given a shelter to upwards of 185,000 women, and within whose wards 5000 pupils from every part of the civilized world, have been instructed in practical midwifery: surely no panegyric is needed here.

"Tanto nomini
Nullum par eulogium."

In everything that Mosse did or undertook he showed a boldness of conception, a largeness of mind, and breadth of view, which at once stamped him to be a man far above the common. No present difficulties or discouragements seemed to have the least effect in making him alter his plans or contract his ideas.

All the essential circumstances connected with the plan, building and arrangements of this great hospital were regulated solely by him; and in all these one sees much to admire, both as to the design and the execution, so that it might well be supposed that Mosse, in addition to being endued with extraordinary foresight, had at his command unlimited pecuniary resources! And yet, as you know, how widely different is this from the real fact.

The conduct of most men is governed by circumstances, but Mosse, on the contrary, was superior to circumstances, and in the end he triumphed.

Gentlemen, you are all, I hope, animated with a desire to attain eminence in your professional walk, to earn the approbation of your fellow-men, and to be useful in your generation. Let me tell

you then, that the most important element of character to ensure success in the pursuit of these laudable objects of ambition, is industry—perseverance—determination.

In the history of Bartholomew Mosse, you have this quality reaching its highest development, and you see around you its enduring results. Of it we may truly say, as is said of him:—

"Miseris solamen instituit."

Him I would hold up as an example worthy your imitation; whilst I point to this edifice as the noble monument of what great things an individual may accomplish by firmness of purpose, and by unflinching perseverance.

LECTURES ON DISEASES OF THE STOMACH.

By DR. LEES,

Physician to the Meath Hospital, Lecturer on Practice of Medicine.

(Concluded.)

DYSPEPSIA.

BISMUTH, IPECACUANHA, NITRATE OF SILVER, TONICS—
MORBID CONDITIONS OF THE APPETITE—EXCESSIVE THIRST.

Subnitrate of bismuth is another remedy much used in stomach affections, but it often fails, from not being suited to the proper case; it is of no use in gouty dyspepsia, or when there is organic disease of the stomach; but Dr. Budd recommends it in the dyspepsia of tubercular phthisis, and in that form caused by some irritation in a distant part, which is characterised by pain in the stomach, with increased secretion of gastric juice. It is best given in doses of from five to ten grains in water, or in a solution of magnesia, or in lime-water. The subcarbonate of bismuth has been lately recommended in preference to the nitrate, as being more soluble in the gastric juice, and not constipating the bowels; I have tried it, but did not find it to possess any advantage over the other. Ipecacuanha is useful as an occasional emetic in some cases of dyspepsia; but in that form in which the gastric follicles are chiefly affected, it is often of more permanent use when given in small doses; and it has been especially recommended by Daubenton, the French naturalist, as a remedy in cases where the digestion is slow, where the food lies heavy on the stomach, and there is an inability for mental or bodily exertion for some time after meals—a form of indigestion, he says, very common in men of middle age who lead sedentary lives; he gave it in the morning fasting, in doses of a quarter of a grain to two grains, just so as to cause a slight vermicular motion in the stomach, but without exciting any pain or nausea; if it does so, this may be obviated by combining it with subcarbonate of ammonia, capsicum, lime-water, or sulphate of quina. Dr. Budd speaks highly in its favour, and says "he is satisfied that it often has

much efficacy in removing the uneasiness and sense of oppression after meals, and the various other evils that result from slow digestion." He also recommends its use in urticaria, the result of indigestion, in the dose of from half a grain to a grain and a half, combined with three or four grains of rhubarb, immediately before dinner.

Nitrate of silver has been strongly recommended by the late Dr. James Johnson in cases of morbid sensibility of the gastric and intestinal nerves; it may be combined with any bitter or aperient extract; and he recommends to give quina (in solution) at the same time, "for that form of dyspepsia which is more marked by the morbid sympathies of distant parts, than by *apparent* disorder in the stomach and bowels themselves." He states also "that no inconvenience can possibly result from the medicine if not continued beyond three months at a time." Vegetable bitters and mineral tonics, especially the preparations of iron, are of great value in the treatment of dyspepsia, but should not be given till all irritability of the gastric mucous membrane has been subdued by diet and medicine; nor should they be given "in organic disease of the stomach, in plethoric states of the system, or if there is a furred tongue, or when the urine throws down a sediment of lithic acid, or of lithate of ammonia."* The best vegetable bitters are quassia, calumba, gentian, and chiretta, which last is much used in India, as it promotes the secretion of the liver, and does not constipate the bowels; I have often found it to answer when the other bitters had failed. As a general rule, these vegetable bitters agree well with those who have become dyspeptic from hard drinking or from nervous exhaustion, and the best time for giving them is about half an hour before meals. Chalybeates are also of great use, (especially in that form of dyspepsia to which scrofulous persons are liable, and hence termed "strumous dyspepsia,")† as they act not merely by improving the quality of the blood, but also as alteratives, particularly when combined with iodine. The ammonia-citrate and ammonia-tartrate of iron are nice preparations, and generally agree well with the stomach, but if there is any disposition to sickness or nausea, or furring of the tongue, Dr. Budd advises to combine them with the bicarbonate of soda or potash. The muriated tincture of iron alone, or combined with dilute muriatic acid, will often be useful, and so will the carbonated chalybeate waters, but in all cases where the preparations of iron are given, you should take care that there is no bilious derangement or congestion of the liver, and that the bowels are in a free state, else the tongue will be furred, and headache will result; indeed in most cases it will be good practice to combine some aperient with these medicines.

Dr. Johnson speaks highly of sulphate of quina,

* Budd.

† Todd.

in doses of half a grain, three times a day, dissolved in some bitter tincture; he says, "it strengthens the digestion, and imparts tone and tranquillity to mind and body." The state of the skin should be carefully attended to, and flannel or silk worn next to it; a warm or opiate plaster over the epigastrium will often be of great service; the feet should be kept warm, especially at night, and to effect this, use mustard pediluvia, or have the feet bathed in cold water for a short time previous to going to bed, and then well rubbed, so as to cause good reaction.

Before concluding the subject of dyspepsia, I wish to say a few words on some morbid conditions of the appetite, which, though not (strictly speaking) diseases of the stomach itself, yet, as the most prominent symptoms are caused by an altered sensibility of the nerves and a modified state of the secretions of that viscus, I think they may be properly considered in this place. 1st, Exaggeration of the natural appetite, termed *Bulimia*. This consists in an excessive or insatiable craving for food, and may vary from that due to exhaustion or mere habitual gluttony, to a state of actual disease, in which the patient gets into most violent excitement, or even frenzy, if not satisfied. Some of these persons digest their food, and become very fat, but others suffer from constant diarrhoea, often very fetid; and emaciate rapidly. This disease may come on suddenly, without any assignable cause, and cease in the same manner, but generally supervenes gradually, and is mostly met with in idiots, epileptics, and insane persons suffering from chronic disease of the brain; but may occur in hysterical, chlorotic, pregnant, and phthisical patients; also in those suffering from intestinal worms; and it is a very prominent symptom in the disease termed diabetes, and also in some cases of mesenteric disease. An abnormal condition of the stomach and intestinal tube has been found in some of these cases; these viscera have been enormously distended, or the ductus choledochus has been found opening into the stomach; the gall-bladder has been wanting, or the intestinal canal has been unnaturally short, in persons affected with this disease. The treatment should be directed to correct the morbid condition of the system which gives rise to the affection, and to reduce the quantity of food gradually. Dr. Copland recommends "an active course of nauseating purgatives, consisting chiefly of the oil of turpentine with castor-oil;" but you will generally find that opium will be of great use as an auxiliary to other treatment. 2nd, Depraved appetite, termed *Pica*, which is manifested by the desire of eating substances totally unfit for food—as cinders, clay,* thread, paper, sealing-wax, hair, glass, pins, needles, and sometimes for things disgusting, as vermin, ordure, &c. Thus I have seen a child about six years

* A remarkable case of this is recorded by Dr. Pickell in the fourth volume of the *Transactions of the Association of the K. & Q. College of Physicians in Ireland*.

old, whose great delight was to roast mice and eat them; and in some cases there is the same perverted taste for fluids—as ink, vinegar; even urine and blood are greedily sought for and drank. A form of this disease has been described by Dr. John Hunter as “dirt-eating,” a practice common with the negroes in the West Indies; but it is probably taken by them to neutralize acid in the stomach. This affection generally depends on some disordered state of innervation of the stomach or some distant part, or upon disease of the brain; it is met with in cases of mania, hysteria, chlorosis, and in anæmic children, especially if suffering from intestinal worms, and to a certain degree in some females when pregnant; but it may occur when none of these conditions are present, and may be practised in such a concealed way as not even to excite suspicion. A curious case is recorded by Mr. Marshall, in the thirty-fifth volume of the *Medico-Chirurgical Transactions*, of “a lady who suffered for many years from sickness and pain in the stomach, with occasional vomiting of blood, and a tumor in the left iliac fossa, which moved freely across the abdomen, and felt like an ordinary placenta. It gave her no pain when she was quiet, nor was it tender to the touch; and was found, after death, to be the stomach which was drawn down to the pelvis, and resembled a champagne-bottle in form; and in the lower half, which constituted the tumor felt during life, were found an immense number of pins, of a purple-black colour, not corroded, varied in size, all bent or broken, many very pointed. The weight of the pins contained in the stomach was nine ounces. In the duodenum was a mass of pins tightly packed, of various shapes, similar to those found in the stomach, and wholly obstructing the tube. These weighed a pound.” It was curious that her husband stated he never had observed her putting pins into her mouth; but her son, seventeen years of age, said he had often observed her biting pins; and her sister said that, when a child, she was fond of eating starch and slate-pencils; and biting pins. The proper treatment for this affection consists in improving the general health, and correcting the state of the nervous system which has induced it. They should be carefully watched, so as to prevent their having access to the forbidden articles. If the patient is pregnant, she should be well purged; if it occurs in a chlorotic female, give aloetic purgatives, with emmenagogues and the preparations of iron. If she be hysterical, treat her with antispasmodics; and if it occur in children, always examine for intestinal worms, and treat them with anthelmintics; regulate the bowels, improve the secretions, and give tonic medicines, with wholesome digestible food.

There is a another peculiar affection, the chief symptoms of which are also referred to the stomach, it is termed *polydipsia*, from the insatiable thirst which characterises it, though there is no

fever, and often but little derangement of the general health; the appetite may be natural and the food well digested, but they often complain of a sensation of sinking at the stomach, with great debility, excessive thirst, and dryness of the mouth and pharynx; but it is a curious fact that if an acute disease supervenes, the thirst, instead of increasing, as we might expect, actually decreases, but increases again on the subsidence of the acute disease. The saliva is scanty and viscid, the skin is generally dry and rough, and they pass a large quantity of limpid urine, very deficient in urea, but not containing sugar or any abnormal ingredient, and hence it has been termed *diabetes insipidus*. It is a rare disease, but two years ago I had a case of it (in this hospital) which I published in the transactions of the College of Physicians.*

This affection has often been mistaken for diabetes, but differs in many respects from it: 1st, it often commences in infancy; 2nd, the general health is not necessarily affected, nor are the generative organs, as in diabetes, nor is there the emaciation and weakness, and ravenous appetite, but above all, the urine is not saccharine. Many, considering this as a nervous affection, have recommended opium, valerian and antispasmodics. My patient was greatly benefited by a mixture containing twenty grains of oxalic acid and a drachm of liquor potassæ dissolved in eight ounces of water, of which he took an ounce every three or four hours; and I also allowed him a pint of porter daily.†

If this disease begins early in life, it gradually increases up to puberty, and remains stationary; but when it attacks adults it may increase rapidly. It is very difficult to cure, and is very liable to relapse; but though it generally lasts for many years, and keeps the patient in a state of debility, yet death seldom results from it. Its causes are very obscure; it chiefly affects the scrofulous and those of a lymphatic temperament, and appears to be hereditary in some families. In the case under my care, the patient attributed it to his being exposed in an open boat with the sea washing over him for some hours.

POISONING BY WAFERS.—Dr. VERRON.—A girl, aged 16, labouring under chlorosis and pica, swallowed a quantity of wafers coloured yellow by chromate of lead, and died on second day. The symptoms which followed the reception of the poison into the stomach were severe pains in the abdomen, convulsions, trismus, dilated pupils, dyspnoea, extreme sensibility of the umbilical region, remarkable rapidity of the pulse, frequent screaming and unconsciousness. Neither vomiting nor diarrhoea occurred. It is strange that in this case neither necroscopic examination nor chemical investigation were made.—*L'Union Médicale*.

* *Dublin Quarterly Journal*, February, 1856.

† Frank advises a drachm of nitrate of potash in that form termed *sal-prunelle*, to be dissolved in a pint of water, and a wine-glassful taken every second hour; and Dr. H. Kennedy has published some cases in which he used nitric acid with good effect.

ON THE VALUE OF THE "ROTLERA TINCTORIA" (KAMEELA),

AS A LOCAL APPLICATION TO HERPES CIRCINATUS.

By WILLIAM MOORE, M.B., T.C.D., M.R.I.A.

Physician to the Institution for Diseases of Children, Pitt-street, &c.

The *Rottlera Tinctoria* is one of the species *Euphorbiaceæ*, found along the base of the Himalayas, and at the Parrell Hill, near Bombay, as well as in other districts of Central India. It is a small sized tree; the substance, Kameela, is the powder with which the capsules, about the size of a cherry, are clothed; it is of a dark red colour, has a peculiar heavy odour, is used as a dye for silk, which it turns a deep bright orange colour. The capsules are gathered in February and March, when the powder is carefully brushed off.

It is about a year since my friend Dr. Benjamin Simpson, of the Bengal army, first made me aware of the valuable anthelmintic properties of this agent, and from his own experience of it, and that of some of his brother officers, I determined to obtain it, which I was enabled to do through the kindness of Dr. Thomas Beatty of the Bombay medical staff, who also enclosed me a letter from Dr. Giraud, Professor of *Materia Medica* in Grant's Medical College, Bombay, in which he says, "The Kameela is the reddish brown powder from the capsules of the *Rottlera Tinctoria*; this powder is procurable in great quantity in the bazaars here, under the name of Kapeela, and is used by the natives as an application for scabies and other skin diseases; its anthelmintic properties appear to be unknown here, but in Bengal it is extensively used as a vermifuge for all kinds of worms, but especially for tapeworm, for which it is successful, after turpentine and kooseo have failed."*

Dr. Beatty considers it an excellent application for ringworm, rubbed over the eruption, moistened with water.

The first case in which I applied it locally, was that of Mary P——l, aged eight years, who was brought to the Institution for Diseases of Children; she had a well-marked patch of herpes circinatus on the neck, about the size of a six-pence; her head also presented several well-defined marks of herpes. On the 20th July I first rubbed the eruption on the neck with the kameela, applied on moistened lint.

22nd July.—The eruption was scarcely perceptible; I re-applied the kameela, which completely removed it. Some days after, another patch appeared on the anterior part of the neck, and one on the left forearm, and in both cases one application

of the kameela sufficed to remove them. The herpes capitis, which is quite cured, was treated with the Unguent Sodæ Carb. (ʒi. to ʒi.) and Lotio Sulphuret Potass (ʒi. to Oi.); the alterative treatment being Hydrarg. c. Cret. gr. i., Pulv. Rhei. gr. iv., Pulv. Ipecac. gr. ½, at bed time, and a teaspoonful of Oleum Jecoris Aselli, three times daily. My stock of kameela at the time being somewhat circumscribed, prevented me applying it to the head in this case.

Case 2.—In the month of July last, Michael R——n, a stout lad, aged about 12 years, presented himself at the Institution for Diseases of Children; he had well-marked herpes capitis about the size and shape of a half-crown-piece over the right parietal bone. I prescribed a purgative of Calomel and Pulv. Jalap Comp., to be repeated after the lapse of three or four days, and at the same time ordered him a mixture containing small doses Iodid Potassium. The local treatment was Ungt. Sodæ Carb. (ʒi. to ʒi.) and Lotio Sulphuret Potass (ʒi. to Oi.) Under this treatment the improvement was manifest, but not so quick as I could have wished; accordingly, on the 3rd of August, I applied the kameela on moistened lint, as in the previous case, and after the third application the patient did not return; and he afterwards told me that it had completed the cure. In this case, all the merit is not due to the kameela, as the carbonate of soda and sulphuret of potash treatment had been in use some time, but the former application certainly expedited the complete removal of the eruption.

Case 3.—G. P., aged four years, a delicate girl, with glandular enlargement, was brought to the Institution, Pitt-street, Oct. 20th, on which day I applied the kameela to a circular patch of herpes on the left shoulder, which was about the size and shape of a florin, and at the same time prescribed Hydrarg. c. Cretâ g. i.; Pulv. Rhei g. iv.; and Pulv. Aromat gr. ½, to be taken every second night.

22nd Oct.—Eruption had almost disappeared; I re-applied the kameela.

26th—Herpes quite gone,

Case 4.—James P., aged two years, a stout healthy boy, had a circular sore of herpes circinatus, on the top of the right shoulder, about the size of a shilling; on the 21st of October last I prescribed alterative powders of Hydrarg. c. Cretâ Rhei Pulv., and Pulv. Aromat., at bed time every second night, and applied the kameela to the eruption.

22nd Oct.—Eruption much paler in the centre, edges still red; re-applied the kameela.

26th Oct.—Mark of the eruption scarcely perceptible.

I think this powder may justly be considered a valuable addition to our local applications in herpes, and I have no doubt, in other allied eruptions, of course coupled with alterative or tonic treatment, or both, as the case may be. As regards the an-

* On the vermifuge properties of this medicine you will find valuable papers by Drs. Mackinnon and Anderson, of the Bengal army, in the "Indian Annals of Medical Science;" and cases published by Dr. Gordon, of H. M. 10th Regiment, in the *Medical Times and Gazette*, 2nd May, 1857.

thelmintic properties of this agent, it is highly extolled by those who have given it a fair trial. The dose of the kameela, as an anthelmintic for an adult, is from $\frac{3}{4}$ ii. to $\frac{3}{4}$ ss. of the powder, and of the alcoholic tincture, $f\frac{3}{4}$ j. However I shall reserve any further remarks on the vermifuge properties of this medicine till some future occasion, when I hope to bring it under the notice of the profession.

TO THE EDITOR OF THE DUBLIN HOSPITAL GAZETTE.

Londonderry, 21st Oct. 1857.

DEAR SIR—I send you notes of a few cases, perhaps of sufficient interest to obtain a place in your *Gazette*. Yours,

THOMAS H. BABINGTON, M.B.

Surgeon, County Infirmary, Londonderry.

ANEURISM BY ANASTAMOSIS OF THE UPPER LIP, CURED BY INJECTION OF PERCHLORIDE OF IRON.

Mary Lynch, æt. 20 , was admitted into County Infirmary 8th July, her upper lip considerably enlarged at the prolabium and towards the right side. In the swelling there is a distinct forcible pulsation, which is controlled by pressure on the coronary arteries.

She states that "some years since she was sucking a thimble, which stuck so fast to the lip that it had to be filed off." Since then the pulsation commenced, has continued and increased, and during the last six months her lip has greatly enlarged in size, and the pulsation has become more violent.

The case was at first treated by attempting to command the circulation by clamps applied over the coronary arteries. This proceeding proved ineffectual.

The tumor was then injected in two points with the solution of perchloride of iron. After an interval of a week, we performed a second injection; this was repeated six times, when all pulsation ceased, and the swelling became solidified; each injection of the perchloride was followed by considerable pain, and burning sensation in the lip and swelling, which subsided in about thirty-six hours. The result has been very satisfactory, and the patient discharged the 19th October, cured.

The instrument used for injection was a glass syringe, with a graduated screw piston, and sharp pointed tube; at each turn of the screw about one-fourth of a drop was discharged. Messrs. Weiss and Sons, London, made the instrument.

VESICO-VAGINAL FISTULA CURED BY THE ACTUAL CAUTERY.

Susan Small, aged 25 years, was admitted into the infirmary on the 8th July. She was confined of her first child six weeks since; had a difficult

labour; the forceps was used. On getting out of bed she found that she could not retain her urine; lying on her back, the urine was partially retained, but in the erect position it was constantly dropping from her; her legs and thighs were much excoriated and her condition was pitiable.

On examination there was found a rent, opening into the bladder, which readily admitted the point of the fore-finger, and was situated about three quarters of a finger's length from the orifice of the urethra; through this opening the urine was seen dropping.

I determined to operate in the manner described by Dr. M. H. Collis, in the *Dublin Quarterly Journal of Medical Science*, No. XLV., and here beg to thank Dr. C. for his kind letters on the subject. Whilst procuring the instruments I kept the patient in bed, and dilated the vagina with sponges of various sizes and thereby prevented the urine flowing over the external parts.

August 7th—On examining the patient prior to performing the operation, I found the opening considerably narrowed, so much so that it was deemed advisable to try the actual cautery. The heated iron was accordingly applied, and Sims' catheter left in the bladder.

On examination, on the third day, the opening looked fleshy and granulating; no urine had passed through it. The surface was touched with the nitrate of silver.

On the eighth day the opening seemed closed up. She was allowed to walk about the ward; no urine passed through the opening.

On the 22nd August she left the hospital, fifteen days after the operation. I have since heard of her, that she is perfectly well.

PREMATURE DISCHARGE OF THE LIQUOR AMNII.

In Nos. 4 and 6 of your present volume, your most respected correspondent, Dr. Montgomery, narrates two cases of premature discharge of the Liquor Amnii. Another may be to some not uninteresting.

I was recently consulted by a lady, mother of four children, who informed me that in her first pregnancy the liquor amnii was discharged two months before the birth of her child. In her second pregnancy the same occurrence took place in the sixth month. In the third, in the fifth month; and in the fourth, in the fourth month.

The children were all born alive.

IODINE INJECTIONS IN OVARIAN DROPSY.—A fatal case has just occurred under M. Maisonneuve, in Paris, in which iodine had been injected into an ovarian cyst. The patient was a young and healthy-looking woman, and the injection was performed on the occasion of the first tapping. Death followed three or four days afterwards. It was stated after the autopsy, that no peritonitis had been found.

OBSERVATIONS ON

THE FLOW OF THE LACTEAL FLUID
IN THE MESENTERY.

By JOSEPH LISTER, Esq., F.R.C.S. Eng. & Edin.

(Read before the British Association.)

The experiments of which a short account will be given in the present communication were performed in the summer of 1853, but have not been hitherto published. The objects for which they were undertaken were, in the first place, to observe the character of the flow of the chyle through the lacteals—a thing which, so far as I know, had never been satisfactorily done; and in the second place, to throw some light, if possible, upon the debated question, whether or not the lacteals possess the power of absorbing solid matter, in the form of granules visible to the human eye. In the experiments made for the former purpose, a mouse having been put under the influence of chloroform, about two hours after partaking of a full meal of bread and milk, the abdominal cavity was laid open by a median longitudinal incision, and the animal having been placed on its side upon a plate of glass, a coil of intestine was drawn out gently, sufficiently far to admit of the microscope being applied to the mesentery, which was kept moistened with water of about 100° Fahrenheit, under a $\frac{1}{2}$ object glass. The lacteals were readily recognised as beautiful transparent beaded cords, the beads corresponding to the situations of the valves, which were observed to be standing open while the chyle corpuscles moved along through the tubes with a perfectly equable flow, at a rate about a quarter of that at which the blood passes through the capillaries. There was nothing like rhythmical contraction to be observed in the vessels, and it was evident that the source of the movement of the fluid was some cause in constant and steady operation. Chyle corpuscles, apparently fully formed, to judge from their size, were observed constantly passing along, even in parts very near to the intestine, the scene of absorption, showing the rapidity with which those corpuscles are elaborated. These observations were repeated several times.

The other set of experiments were conducted in the same manner, except that some insoluble granular material, such as indigo, carmine, or flour of sulphur, was mixed with the food. The animals partook freely of the mixture, which also passed on into the intestines; yet none of the colouring particles were ever to be seen in the lacteals by aid of the microscope, although, had they been present in the granular form in the chyle, they would have been certainly detected, being quite different in appearance from the normal constituents of the fluid. It may be imagined that the substances administered exercised a poisoning influence and paralysed the function of absorption. There was, however, no appearance

of any such thing; the chyle presenting the same characters, both as to its constitution and rate of flow, as when simple bread and milk had been alone administered. These facts, though not, perhaps, absolutely conclusive, appear to throw great doubt upon the interpretation which has been given of alleged cases of absorption of indigo and some other granular substances, and render it probable that the lacteals are incapable of admitting visible solid particles through their parietes.

Dr. REDFERN asked Mr. LISTER whether he had observed lymph corpuscles prior to the passage of the fluid through lymphatic glands.

Mr. LISTER replied, that though his observation was made very near the intestine, he could not say, with absolute certainty that the fluid had not passed through lymphatic glands.

Dr. REDFERN then remarked that the corpuscles might have been derived from the lymphatic glands of the alimentary canal, known as solitary and aggregate glands.

ON CERTAIN

PATHOLOGICAL CHARACTERS OF THE
BLOOD CORPUSCLES.

By J. P. HENNESSY, Esq.

(Read before the British Association.)

The series of microscopical observations, of which I propose submitting certain results to this subsection, were commenced in the early part of the year 1853, and concluded in March 1855. I shall first proceed to state to you two results with regard to healthy blood:—

1st.—That the particles in the lower part of the clot were smaller than those in the upper part, and that in the bloody serum the particles which subsided to the bottom of the vessel were smaller than those which floated at the top. In every case the redness appeared to be in an inverse proportion to the size. 2nd, That after removing the greater part of the fibrine by stirring the blood with a bundle of twigs, the particles which were not disintegrated were larger and paler than usual.

With regard to inflamed blood—that is, blood drawn from a patient suffering from an inflammatory disease, or blood taken from a part of the body in a state of inflammation—I arrived at the following results:—

1st, That the particles were smaller and darker than those of healthy blood; the average size of the former being the 4,500th part of an inch. 2nd, That when some of these particles were exposed to the air and dried, they became larger, attaining, in general, the size of healthy particles treated in a similar manner. (Mr. Hennessy exemplified this by a verbatim extract from his notes.) 3rd, That where the blood drawn presented the buffy coat, the few particles among the meshes of fibrine in the upper part of the clot were very large compared with those at the

bottom of the clot. 4th, That on shaking a vessel containing blood from which the clot with buffy coat had been removed, the particles which subsided most rapidly were found to be the smallest and darkest.

The principal fact which may be gathered from these results is one to which I wish to direct particular attention, viz., that the particles in blood in a state of inflammation are smaller, darker, and of higher specific gravity than those of healthy blood. Regarding this change in the blood corpuscle as one of the *propria* of inflammation, we are led at once to consider the connection it may have with other phenomena attendant on that state. The questions arise, how far it may account for the appearance of the buffy coat? how far it may go to explain the well-known changes of temperature, colour, size, and pain? and whether it may not also furnish some explanation of the action of certain therapeutic agents? In short, how far this molecular change may be employed as the basis for a satisfactory theory of inflammation? The immediate or rather the concomitant physical phenomena attendant on the contraction of the blood particles, are, a development of latent heat, an increase of colour, and an increase of specific gravity. Whatever may be the amount of heat developed, however small in each particle the change of colour or increase of specific gravity may be, these are inevitable results of the contraction. On the other hand—and this is a point of great interest, to which I will shortly advert—when the particles are regaining their normal state, an opposite series of phenomena must be presented. Let us apply these results to the physical signs of inflammation. The development of latent heat will explain the rise of temperature. The contraction will effect the colour of an inflamed part, not only by rendering the particles darker, but by permitting them to flow into vessels from which their size had previously excluded them. In becoming smaller they will necessarily become harder, and be enabled to burst through the walls of the capillaries, which would account for the phenomena of infiltration and pain. The increase in specific gravity, and a diminution in size, are the two causes which conspire to form the buffy coat; the former causing the particles to sink more rapidly, and the latter allowing them to pass through the coagulating meshes of fibrine with less chance of of being obstructed.

With reference to the effect of therapeutical agents, Mr. Hennessy quoted the observations of Muller, Copeland, Wedemeyer, and Hastings, &c. In corroboration of his statement that the particles became smaller, he quoted Dr. Gulliver, *Phil. Mag.* vol. ii., 1840, page 326; Mr. Wharton Jones, *Guy's Hospital Reports*, vol. vii., page 34; *Donné Journal Hebdomadaire*, No. 40, vol. vi.; Professor Schultz, (through the *Lancet*, 38, 39, vol. ii., pp. 713, &c.); Dr. Kölliker, *Mikroskopische Anatomie*, page 253; Heller, Emmert,

Barry, and others. With reference to the dilatation of the blood particles, Mr. Hennessy quoted Mr. Wharton Jones, Dr. Currie, &c. With reference to the specific gravity, he quoted the researches of Bequerel and Rodier, Heller, M. Lebert, Dr. Polli, and Dr. Rees. With reference to the changes of temperature he quoted Dr. Traube, *Über Krisen und Kritische Tage*, Dr. Roger, Sir B. Brodie, *Physiological Researches*, p. 121, Professor Dunglison, and Mr. Earle.

It has been noticed by Mr. Wharton Jones that when the inflammatory state is passing off, the particles become larger. This exactly corresponds with the well-known observations, that the decline of acute disease is marked by an abnormally low degree of temperature, even whilst the action of the heart is still keeping the circulation above the normal standard.

Mr. Hennessy stated that he was pursuing his inquiries into the microscopic differences between venous and arterial blood, but that as yet he had not arrived at any satisfactory conclusions on the subject. The difficulty of preparing specimens of venous blood were very great. He adverted, however, to observations of Prevost and Dumas, of Liebig the younger, of Dr. Davy, and of M. Beclard, with respect to the relative capacities for heat and to the relative specific gravities of arterial and venous blood, for the purpose of suggesting an extension of the molecular theory to the phenomena of animal heat.

Bibliography.

Asylum Journal of Mental Science. No. 22, Oct. 1857.

This number opens with a report of the Annual Meeting of the Association of Medical Officers of Asylums and Hospitals for the Insane, which was held in London on 2nd July. The address of the President, Dr. Forbes Winslow, on this occasion, is deserving of special notice. The speaker dwelt in the most feeling and eloquent terms on the important and responsible position which the physician of the mind is called upon to occupy, and also invited the serious attention of the association to the practical difficulties which affect the due maintenance of their high and honourable position. He attributes much of the existing evil, as regards the present recognised status of psychological physicians, to three causes:—1st. To the conduct of a few narrow-minded and ignorant men, who have improperly had the care of the insane, and who have, by their very questionable proceedings, tended to lower the status of the entire body to their own base level. 2. The effects of legislative enactments upon the character of the psychologists, and the condition of the insane. 3. The ignorance exhibited by the public of the real characteristics of insanity and of the treatment necessary for its cure. At this meeting Dr. Tuke read some valuable "Observations on the treatment of insanity, where refusal of food is a prominent symptom." This author strongly advocates the early adoption of forced alimentation, before the strength fails and fatal exhaustion is imminent. Next follows a continuation (from p. 334, vol. iii.) of Dr. Busbmill's elaborate and careful researches on "The Pathology of Insanity," containing a well-digested résumé of the several changes exhibited in the various forms of mental disorder, in reference not only to alterations of

the brain and its appendages, but also to the thoracic and abdominal organs—a valuable and practical paper. An examination of the question, “How far civilization is favourable to the development of mental disease,” by Dr. Tuke, as well as Dr. Noble’s paper on the use of Opium in the treatment of insanity, will be found worthy of careful perusal. The present number closes with the memorial of Miss D. L. Dix, addressed to the Senate and House of Representatives of the United States in Congress assembled, praying a grant of land for the relief and support of the indigent curable and incurable insane in the United States. The unparalleled horrors exhibited to view in this extraordinary record of female philanthropic exertion will be read with painful interest.

Observations on the Human Crania, contained in the Museum of the Army Medical Department, Fort Pitt, Chatham. By GEO. WILLIAMSON, M.D., pp. 87.

The splendid collection of Crania in the Fort Pitt Museum, containing upwards of five hundred specimens, and exhibiting almost every variety of skull shape to be observed among the several nations of the earth, affords a choice and copious range of material for the practical study of craniology, not to be equalled, perhaps, by any other collection in the world. Upon the author of the present “*Observations*” has devolved the task of carefully arranging and classifying those crania, so as to exhibit their several peculiarities in the most striking point of view. He divides them into four classes, viz.: 1st, oval or symmetrical skulls; 2, those with prognathous jaws, or having the nasal bones on the same plane; 3, skulls with superciliary ridge prominent and overhanging the face; and 4, broad and flat-faced skulls. Were we disposed to be very critical, we might object to the employment of some of these designations, as not being sufficiently exclusive; for example, several crania not included in the first class are yet described in the course of the work, as having a decidedly oval shape. We fully agree, however, with the author, that “it is very difficult to convey an accurate idea of the various differences observed in skulls by description,” without the aid of drawing. Considerable value is attached to the form of the anterior nasal aperture in the several races, but taken of course in connexion with the other characters. The various distinctive forms of this opening are exemplified by means of outline drawings. We expect shortly to see in the museum of the Royal Dublin Society, a collection of casts from the Fort Pitt skulls, and to this the present brochure will serve as a valuable guide.

Outlines of Fever, or Selections from a Course of Lectures on Fever, being part of a course of Theory and Practice of Medicine. By ROBERT D. LYONS, M.B., &c. Part I. Dublin: FANNIN & Co. and BROWN & NOLAN. 1857.

Dr. Lyons’s object in these lectures is, “to bring within the reach of the student, in a convenient form, the more recent results of inquiries into the pathology and therapeutics of this formidable class of disease; the works of the great writers on fever being so numerous, and scattered through so many languages, that they are difficult of access, not only to students, but also to practitioners.” The Author, in the first lecture, dwells upon the great ravages made by typhus from time to time in this and other countries, and alludes particularly to the losses occasioned by it in the late Eastern campaign; from all which he comes to the fair and legitimate conclusion, that “a complete and thorough education in the pathology and therapeutics of fever constitutes the first and most essential requirement of the medical officer in the public service.”

As his definition of fever, Dr. Lyons adopts that of Cullen, as modified by Christison. We trust that Dr. Lyons may be induced to continue the publication of this series of lectures, the first No. of which we strongly recommend to the perusal of all practical physicians.

Selections from British & Foreign Journals.

CASE OF PNEUMOMYCOSIS (ASPERGILLUS PULMONUM HOMINIS).

By Professor VON DUSCH, and Dr. A. PAGENSTECHER, of Heidelberg.

On examination of the lungs of a woman aged 69, who died of tuberculosis of the lungs and urino-genital apparatus, a portion of the superior lobe of the right lung was found in a state of gangrene, the fluctuation of which could be felt from without.

The cavity was for the most part filled with a brown odourless fluid, and was not in connexion with a large bronchial tube. In the upper part, and where the fluid did not reach, there was a small patch, which from its grey-green hue and from its resemblance to fine velvet, led to the supposition that it was a mouldy formation.

Under the microscope, however, the fungus discovered in gangrene of the lungs by Hasse of Heidelberg, was recognised (see Küchenmeister’s *Parasiten*). The investigation afforded nothing to add to Virchow’s description (*Archiv ix. s. 564—575*) and the more recent statements of Friedreich (*Ibid. x. s. 510*). A wood-cut is given of the fungus as it appeared under the microscope, and a minute description of the appearances.

So far as the existence of a mouldy condition of the lung is concerned, this case differs little from those already known; for in all necrotic softening of the lung tissue was present, with the exception of Virchow’s case, in which the mouldiness of the bronchi was not connected with any manifest alteration of the walls.

The case now given differs from those previously communicated, by the fact of the pneumomycosis being combined with tuberculosis of the lung. It must be admitted, however, that the latter stood in no near relation to the gangrene and the mouldiness.

The conditions under which the development of *Aspergillus* has taken place in the lungs up to the present, exhibit a strong analogy. It appears that a necrotic state of the lung affords the most favourable soil for the sporules introduced by inspiration from without. Why these parasitical growths do not take place in all or in the greater number of cases of gangrene of the lung, depend either on the absence of the pilzsporules of this kind from the air, or may be caused by some peculiarity of the individual case.

It has been already remarked, that the mouldiness was only observable on dry parts of the gangrenous lung, which was also stated by Virchow, while the moist parts were free.

Attention must also be especially directed to the circumstance that in four cases (of Virchow, Hasse, Friedreich, and of the communicators of the present), the necrotic parts did not give out the odour proper to gangrene, and that the evolution of the so called gangrenous gases may have been prevented, a condition which may attract observation in future cases. Whether dead lung tissue and the bronchial secretion of man be the only favourable locality for the development of the *aspergillus*, and for its attaining maturity, is a question yet to be determined. From the characteristic form of the parasite, we may hope to be able to recognise it if it presents itself out of the body—*Virchow’s Archiv*, b. xl. s. 564.

HOOPING COUGH—GENERAL EMPHYSEMA.

Dr. Bierbaum relates a case in which general emphysema occurred in the course of hooping cough. A male child of three years of age, had laboured under hooping cough for four weeks. The paroxysms of cough were not severe; fever, loss of appetite, and drowsiness, supervened; bronchitic rales were audible on auscultation of the chest. On the tenth day a remarkable emphysematous swelling of the face was observed; the eye could not be opened; the neck was also the seat of

emphysema, particularly the laryngeal and tracheal regions; the head appeared to be bent backwards; the body was much swollen; the linea alba presented the appearance of a deep groove. This was also the case with the raphe of the scrotum. The lower extremities were engaged, but not to so great an extent. The drowsiness and the fever departed on the occurrence of emphysema. The fits of coughing were not violent; the resonance of the chest was tympanitic, the respiration puerile, but no rales were to be heard. Under the use of acetos lividus, camphor liniment, aromatic fomentations and friction, the emphysema disappeared and the child recovered. The author believes that an intercurrent bronchitis was the cause of the emphysema. (?)—*Preussische Ver-Zeitung*.

INTESTINAL CONCRETIONS.

Dr. Schallenmüller reports a remarkable instance of intestinal concretions, which occurred in a woman aged 35, who for two years had complained of disturbance of the digestion, colic, flatulence and alternating constipation, and diarrhoea. At length a severe form of fever set in and abdominal pains were so depressing that morphia and chloroform were had recourse to, but without affording any alleviation. On examination of the body of this woman after death, the abdominal organs were found displaced, the small intestines much enlarged, and in the large intestines were twenty concretions of various sizes, from that of a pigeon's egg to the size of a clenched fist; they were of an oval shape, greenish, loam like, and the surface was so hard as to give a ringing sound on being struck. The largest masses were found in the colon ascendens, which in fact was quite filled with them. The ovaries were small and shrivelled, and in connexion with them were cysts of large size. The rectum was displaced towards the right side.—*Württemberg Correspondenzbl.*

A NEW REMEDY FOR TAPEWORM.

Dr. Brehens notices the efficacy of panna root, a product of South Africa, in expelling tapeworm. Of ninety trials it was perfectly successful in eighty-three cases, the parasite being expelled with the head; and in no instance was there a relapse. The patient is to be prepared by a restricted diet, by abstinence from spirituous drinks, and in the event of constipation existing, by the administration of Carlsbad salts or laxative enemata. The dose of the panna root is a drachm to one and a half drachm; to be divided in quarters, and administered every quarter of an hour. In some time after the last portion, castor-oil should be taken. The average time required for the cure is four and a half hours. Congestion of the head may occur, but it passes off; and occasionally vomiting takes place, but if an hour has elapsed from the reception of the medicine, the cure is not interfered with.—*Deutsche Klinik*.

THE ACTUAL CAUTERY IN ANGINA DIPH- THERITICA MALIGNA.

Danoin recommends with much earnestness the application of the cauterium majus in these diseases. The iron is not to be red-hot, only brought to a temperature of 100 or 109, by being heated in saturated solution of salt. The instrument is an iron ball, with a handle. The iron is to be applied to the affected parts for five or six seconds; the result is, the separation and exfoliation of the pseudo membrane.

In an epidemic of malignant *angina diphtheritica*, Danoin treated seventeen cases in this manner, of which fourteen recovered. This kind of cauterization is not in general very painful; the most distressing consequences of the application is difficulty of swallowing, which, however, does not continue for more than from twenty to forty-eight hours. More severe symptoms were only observed in one case.—*Gazette Medicale de Strassbourg*.

THE WATERS OF CARLSBAD AS A REMEDY FOR DIABETES MELITUS.

Dr. Fleckles of Carlsbad, who, as "Brunnenarzt," has practised for twenty-four years, speaks favourably of the Carlsbad springs as a remedial agent in the treatment of melituria. The cases in which the greatest amount of benefit appeared to be derived from the waters, were those which were complicated with affections of the liver and with gout. In most instances in which the waters were given, the result was the diminution of the quantity of urine, and also of the contained sugar; the specific gravity, moreover, fell remarkably. The disease, apparently arrested during the summer by the internal and external use of the waters, did not always return in the following winter, the season in which relapses so frequently occur. The conclusion come to, however, by Dr. Fleckles is, that except in cases complicated as mentioned above, the waters have not often proved efficacious.—*Zeitschrift der k. k. Gesellschaft der Aerzte zu Wien*.

TRAUMATIC DIABETES.

Dr. Herrmann Itzigsohn relates a case of diabetes which he traces to an injury of the head. A smith of moderate strength, aged 38, unmarried, and previously of good health, received a blow of an axe on the head about the middle line; he immediately experienced great distress and difficulty of passing urine. These symptoms disappeared, but diabetes gradually supervened. The jaundiced hue of the conjunctiva, and symptoms referable to the liver, indicated that this organ had become engaged, only this symptom did not occur until a late period in the course of the disease. Dr. Itzigsohn considers this case of interest, first from the traumatic cause, and secondly from the hepatic affection. Referring to the theory of Bernard, he thinks that the fourth ventricle might have been injured by a contrecoup, or an extravasation have taken place in this region. It is possible that thus the disease may have been induced, but not probable, as the patient never suffered from any symptom referable to the head. Diabetes, however, may have its origin in the brain more frequently than is believed, and the liver become secondarily affected.—*Archiv für Pathologische Anatomie und Physiologie, and für Klinische Medicin*.

PROPAGATION OF DISTEMPER (MILZ- BRAND) FROM ANIMALS TO MAN, AND "VICE VERSA."

Professor Albert Krause has lately established the communicability of this fatal distemper from the lower animals to man, and by a series of experiments has also proved that the disease may be propagated from man to sheep, by inoculation. A man, after having skinned a sheep which had distemper, sickened and died. The symptoms which he presented during life, and the appearances observed on dissection of the body, threw ample light on the nature of the disease. With the blood of this man a sheep was inoculated, which died after thirty hours, and with its blood another animal was inoculated, and so on, until seven others were destroyed; the eighth animal experimented on did not die of this operation. Death took place in each case after a period which varied from thirty to forty hours from the reception of the blood by inoculation. In the bodies the spleen was found disorganised, and the blood had assumed the appearance of tea. Under the microscope the blood corpuscles were found to be club-shaped, and this was observed during life; even in the animal which had been last inoculated, the blood presented the appearance during its illness, but it no longer existed on its recovery. In addition, vibrios were discovered in the blood of the dead animals. These observations leave no doubt that in this distemper and in other analogous

disease, the alteration of the blood plays the most important part. Professor Krause, after he had made these sections felt a sensation of heaviness in his left hand and foot, and as they were asleep; he also experienced in these parts a sensation of formication. After some days these symptoms disappeared under frictions of Liq. ammon. vinos. Six days later, symptoms referable to the brain, such as noises in the ears and spectral illusions, set in, but they also soon disappeared. In the performance of the sections he had not injured himself, but he had examined the cavities of the animals with his left hand, upon which there was a recent cicatrix; he had, however, taken the precaution of oiling his hand previous to making the *post-mortem* examinations—*Deutsche Klinik*.

AMPUTATION AT THE KNEE JOINT, LEAVING THE ARTICULAR SURFACE ENTIRE.

At the first meeting this session of the Western Medical and Surgical Society, the President, Mr. Lane, described this operation as one which ought always to be adopted in those cases where the disease was confined to below the joint, in preference to the more common practice of removing the femur at its lower third. Mr. Lane stated that he had, for the first time, in England, performed this operation about five weeks ago, and exhibited the subject to the members. It had been performed in Glasgow in 1847 once, and in the Crimea seven times, in three of which the patient recovered. It had been performed eighteen times in America with five deaths, and twenty-eight times on the continent with twelve deaths, giving a per-centage of thirty-one per cent. deaths, while that from amputation of the thigh was about forty-three and a-half per cent.; hence the recommendation of the present plan. He described the operation, recommending a large anterior flap to be made in front of the joint down to the insertion of the ligamentum patellæ, which was to be turned up and the knife carried through the joint, and a small posterior flap to be then made, so that in healing it would draw the interior flap over the articular surface, the cicatrix being then behind the joint. The advantages of this plan were apparent in the decreased mortality, and in the after usefulness which would arise in the stump being capable of bearing the pressure of the body better than does the divided femur. Mr. Syme and Mr. Ferguson had recommended a similar operation, but it differed in the removal of the articular surface, and in the recommendation to make a large posterior flap, which was objectionable on account of the tissues of the calf being unaccustomed to pressure, and unfit for the proposed work.

EXTRA-UTERINE PREGNANCY,

CONFIRMED BY A POST-MORTEM EXAMINATION AFTER A PERIOD OF FIFTY-TWO YEARS.

A woman, aged 75, who died in the Salpêtrière in Paris, was the subject of this phenomenon.

In the year 1804, she presented the usual signs of pregnancy, and all proceeded regularly up to the seventh month, when the explosion of the Grenelle powder magazine took place, which shook all Paris, and caused many women to abort. She was much frightened by this event, and felt strong movements of the fœtus, and at the same time labour pains, which, however, soon subsided. In the ninth month pains again occurred, which were more severe, and lasted longer, but at length ceased altogether. A physician, who was sent for, did not discover anything indicative of an approaching delivery. An examination disclosed a normal condition of the uterus; but an undefined tumor could be felt in the abdomen. The woman was persuaded to the last moment of her life that she had a child in her abdomen.

The necropsy exhibited a healthy uterus, which did

not present the appearance of a cicatrix; the ovaries were normal.

In the cavity of the peritoneum there was a little serous fluid, and a large tumor which was almost free; this was divided into three sacks, one of which contained a reddish-brown coagulated mass, another hair, and the third all the bones of a skeleton, with the teeth of the first and second period of dentition.—*L'Union Med.*

HYDROPHOBIA IN MAN.

Dr. Wagner, of Danzig, communicates three cases of hydrophobia, one of which occurred six months after the individual was bitten by an animal suspected of being mad. In each of the three cases the termination was fatal. Chloroform inhalation was had recourse to in all, and although not evincing a curative power, it had the effect of notably diminishing the severity of the paroxysms, inducing sleep, and enabling the patient to take fluid nourishment. The pupils, enormously dilated during the access of a paroxysm, became contracted under the influence of the chloroform, and remained so after the narcotic effects had passed off, and until the next fit, when they suddenly became dilated again. The frequency of the pulse rapidly rose at the commencement of each paroxysm, but gradually fell again, so that it came down from 15 to 20 beats towards the end. The results of these cases encourage to further trials.—*Deutsche Klinik*.

ASSOCIATION OF THE KING AND QUEEN'S COLLEGE OF PHYSICIANS IN IRELAND.

OFFICERS FOR THE SESSION 1857-58.

President—Sir Henry Marsh, Bart.

Vice-Presidents—William Stokes, M.D., M.R.I.A., Regius Professor of Physic; Charles P. Croker, M.D., M.R.I.A.

Council—Dr. Fitzpatrick; Dr. Henry Kennedy; Dr. M'Clintock; Dr. E. B. Sinclair; Dr. Atthill.

Treasurer—Dr. George A. Kennedy.

Secretary—Dr. Moore.

The first open meeting of this Association was held on Wednesday the 4th. The President in the Chair. Valuable papers were contributed—by Dr. Montgomery, on the "Reciprocal Sympathies between the Uterus and Bladder;" by Dr. A. Smith, on "Hepatic Disease;" by Dr. Lees, on "Functional Disease simulating Cholera;" and by Dr. MacSwiney, on "Hæmorrhage."

BELFAST BRANCH OF THE MEDICAL BENEVOLENT FUND SOCIETY OF IRELAND.

The stated quarterly Committee Meeting of this local branch of the above Society was held on the 2nd instant, in the Library-room of the Medical Society, General Hospital—Dr. Patterson in the Chair—when a satisfactory report was made of the progress of this branch, and the successful efforts of the Committee to increase the interest on its behalf, by obtaining additional subscriptions; and in reference to which a letter was now read from the Lord Bishop of Down, warmly approving of the benevolent objects of the Society, and promising it his support—an example worthy of being generally followed by all who feel it a luxury to do good, especially in the case of the widow and the orphan. The following subscriptions were also acknowledged and received for the current year, viz.:—Dr. J. S. Reid, Belfast, £1; Surgeon J. S. Dickson, Belfast, 10s.; Surgeon H. Johnstone, Belfast, 10s. 6d. The death of the late Dr. M'Gowan, of Carrickfergus, having been reported to the meeting, a resolution was unanimously passed, deeply regretting his removal, he having been an old member of the Committee, and a steady friend to the Society for a lengthened period; after which the meeting separated.

APPOINTMENTS.

MR. TRAVERA.—This distinguished surgeon has just been appointed Surgeon-General to her Majesty, in the vacancy occasioned by the decease of Mr. Keate.

THE ARMY.

WAR OFFICE, FALL-MALL, OCTOBER 30.

23rd Foot—Staff Surgeon of the Second Class Patrick Sinclair Laing, to be Surgeon, vice Macfarlane, deceased.

HOSPITAL STAFF.

Staff Surgeon of the Second Class Eneas Mackintosh Macpherson, from half-pay, to be Staff Surgeon of the Second Class, vice Laing, appointed to the 23rd Foot.

Assistant Staff Surgeon W. M. Trestrall has been permitted to resign his commission.

Acting Assistant Surgeon John Alexander Harvey has been permitted to resign his appointment.

WAR OFFICE, FALL-MALL, NOVEMBER 2.

Royal Artillery—Assistant Surgeon Wood, from the Staff, to be Assistant Surgeon, vice Fisher, promoted on the Staff; Assistant Surgeon Oswald Home Bell, M.D., from the Staff, to be Assistant Surgeon, vice Kennie, promoted on the Staff; Staff Surgeon Joseph Marmaduke Taylor, from the Staff, to be Assistant Surgeon, vice Halsahan, promoted on the Staff; Assistant Surgeon Decimus Filius De Hodgson, M.D., from the Staff, to be Assistant Surgeon, vice Betta, resigned.

4th Regiment of Foot—Staff Surgeon of the Second Class Richard Francis Valpy De Lisle, to be Surgeon.

6th Foot—Surgeon William Godfrey Watt, from the 99th Foot to be Surgeon.

6th Foot—Staff Surgeon of the Second Class George Hyde, M.D., to be Surgeon.

7th Foot, Staff Surgeon of the Second Class Edward Scott Docker, to be Surgeon.

8th Foot—Assistant Surgeon John Madden, from the 43rd Foot, to be Surgeon.

9th Foot—Staff Surgeon of the Second Class Brinsley Nicholson, M.D., to be Surgeon.

18th Foot—Assistant Surgeon Washington Patton, from the Staff, to be Assistant Surgeon, vice Lamprey, promoted on the Staff.

16th Foot—Assistant Surgeon Edward L'Estrange, M.D., from the Staff, to be Assistant Surgeon, vice Fraser, promoted on the Staff.

39th Foot—Assistant Surgeon John M'Lechle, from the Staff, to be Assistant Surgeon, vice Douglas, promoted on the Staff.

43rd Foot—Assistant Surgeon James Good, from the Staff, to be Assistant Surgeon, vice Madden, promoted in the 8th Foot.

46th Foot—Assistant Surgeon Henry Carden Herbert, from the Staff, to be Assistant Surgeon, vice Peake, promoted on the Staff.

58th Foot—Assistant Surgeon Eugene M'Shane, from the Staff, to be Assistant Surgeon, vice Montgomery, promoted on the Staff.

60th Foot—Assistant Surgeon Robert Owen Hayden, from the Staff, to be Assistant Surgeon, vice Nicholson, promoted on the Staff; Assistant Surgeon Frederick William Wade, from the Staff, to be Assistant Surgeon.

61st Foot—Assistant Surgeon Charles Mackinnon, from the Staff, to be Assistant Surgeon, vice Reade, promoted on the Staff.

68th Foot—Assistant Surgeon Alexander Neill, from the Staff, to be Assistant Surgeon, vice White, promoted on the Staff.

67th Foot—Assistant Surgeon Robert Heard, M.D., from the Staff, to be Assistant Surgeon, vice Shell, resigned.

90th Foot—Assistant Surgeon Edward Joseph Crane, from the Staff, to be Assistant Surgeon, vice Nelson, deceased.

92nd Foot—Assistant Surgeon David Shorter Skinner, from the Staff, to be Assistant Surgeon, vice Grier, deceased.

99th Foot—Assistant Surgeon Richard Cooper Todd, from the Staff, to be Surgeon, vice Watt, appointed to the 6th Foot; Assistant Surgeon G. Whitle, from the Staff, to be Assistant Surgeon, vice James, appointed to the 87th Foot.

Rifle Brigade—Assistant Surgeon William Alexander, from the Staff, to be Assistant Surgeon.

Cape Mounted Riflemen—Assistant Surgeon Joseph Richard Kehoe, from the Staff, to be Assistant Surgeon, vice Singleton, promoted on the Staff.

HOSPITAL STAFF.

Surgeon William Freeman Daniell, M.D., from the 1st West India Regiment, to be Staff Surgeon of the Second Class, vice De Lisle, appointed to the 4th Foot.

Assistant Surgeon John Gibbins, from the Staff, to be Staff Surgeon of the Second Class, vice Hyde, appointed to the 6th Foot.

Assistant Surgeon James Lamprey, M.B., from the 16th Foot, to be Staff Surgeon of the Second Class, vice Docker, appointed to the 7th Foot.

Assistant Surgeon Herbert Taylor Reade, from the 61st Foot, to be Staff Surgeon of the Second Class, vice Nicholson, appointed to the 9th Foot.

WAR OFFICE, FALL-MALL, NOVEMBER 6.

Royal Artillery—Assistant Surgeon George Davidson Milne, M.D., from the Staff, to be Assistant Surgeon, vice Allinson, promoted on the Staff.

59th Foot—Assistant Surgeon William Langford Farmer, from the Staff, to be Assistant Surgeon, vice M'Gregor, promoted on the Staff.

60th Foot—Assistant Surgeon William Silver Oliver, M.D., from the Staff, to be Assistant Surgeon, vice Biddle, who has resigned.

68th Foot—Assistant Surgeon Augustus Oliver Applin, from the Staff, to be Assistant Surgeon.

69th Foot—Assistant Surgeon John Henderson Whittaker, from the Staff, to be Assistant Surgeon.

76th Foot—Assistant Surgeon Alexander W. Beverish, M.D., from the Staff, to be Assistant Surgeon, vice Willocks, promoted on the Staff.

81st Foot—Assistant Surgeon William James Mullen, from the Staff, to be Assistant Surgeon, vice Auchinleck, promoted on the Staff.

83rd Foot—Assistant Surgeon Thomas Rawlings Mould, from the Staff, to be Assistant Surgeon, vice Touch, promoted on the Staff.

84th Foot—Assistant Surgeon James Cruise, from the Staff, to be Assistant Surgeon, vice La Preste, promoted on the Staff.

86th Foot—Assistant Surgeon Charles Henry Browne, from the Staff, vice Kellie, promoted on the Staff.

87th Foot—Assistant Surgeon Davis Chambers M'Fall, from the Staff, Assistant Surgeon, vice Jones, promoted on the Staff.

HOSPITAL STAFF.

To be Acting Assistant Surgeons—James Gideon Criss, Gent, Charles O'Callaghan, Gent.

DEATHS.

November 9, at the advanced age of 84 years, Sir ANTHONY CLARK, M.D., Surgeon to the Bank of Ireland, and late Surgeon to the Metropolitan Police.

November 6, in the 78th year of his age, EDMUND DAVY, F.R.S., for thirty years Professor of Chemistry to the Royal Dublin Society.

BOOKS, ETC., RECEIVED.

Archives of Medicine, edited by Lionel S. Beale, M.B., F.R.S. No. 1. London: 1857.

Tenth Report of St. Mark's Ophthalmic Hospital and Dispensary for Diseases of the Eye and Ear. 1855-56. Dublin: 1857.

Outlines of Fever, or Selections from a Course of Lectures on fever, being part of a Course of Theory and Practice of Medicine delivered by Robert D. Lyons, M.B., F.R.C.S.I., M.R.I.A. & Lecture 1. Dublin: 1857.

The Uremic Convulsions of Pregnancy, Parturition, and Childbed. By Dr. E. Brann.

On the Treatment of Contracted and Stiff Joints. By Robert I. MacDonnell, M.D. Montreal: 1857.

COMMUNICATIONS RECEIVED

From Mr. Brough; Dr. Hudson; Dr. Harrison; Dr. Babbington; Dr. Bernard; Dr. Montgomery; Mr. S. Cusack; Dr. W. Mori; Dr. Morgan (Sunderland); Dr. O'Neill (Lincoln); Mr. Collis; Dr. Moore.

ERRATUM.

In the Chart, page 333, Dr. Harrison's name should have been inserted as one of the visiting Surgeons at Stevens' Hospital.

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ILLUSTRATIONS OF THE RECIPROCAL SYMPATHIES BETWEEN THE UTERUS AND BLADDER IN WOMAN.

By W. F. MONTGOMERY, M.D.

Late Professor of Midwifery in the School of Physic
in Ireland.

(Read before the Medical Association of the College of
Physicians, 4th November, 1857.)

It is familiar to us all, that, in the human female, there is an intimate reciprocal sympathy between the uterus and bladder, and other parts of the urinary apparatus; so that, under a variety of circumstances, when the former organ is the seat of any anomalous action, or brought into a state of exalted sensibility, whether from natural or morbid causes, the latter is not only liable, but very apt to sympathize, and suffer correspondingly.

This is constantly exemplified in the increased urinary irritation so often accompanying ordinary healthy menstruation, and still more remarkably, when the latter function happens to be painfully performed. Again, in early pregnancy, the same thing is observed; and the remark is trite, that morbid actions in the uterus, whether benign or otherwise, often have the earliest announcement of their invasion, in symptoms of disturbance first noticed in the functions of the bladder.

Thus, congestion or slight ulceration of the cervix uteri, and still more strikingly, malignant affections of that part, frequently excite, in the first instance, in the patient's mind, only apprehensions of gravel, or some vesical disease, for which alone she is induced to seek advice; but woe betide us, in this and many other circumstances, if we let ourselves be beguiled into the belief that because a particular organ or locality is affected with certain anomalous symptoms, it is therefore the seat of some disease, of which these symptoms are to be taken as indications; and so prescribe. Could we, for instance, expect to cure the itching of the nose and angle of the eye which accompanies the presence of intestinal worms, by applications to the Schneiderian, or conjunctival membrane.

Mrs. C. had, for a long time, intense, intolerable, distracting itching of the perineum and anus, which really rendered her life miserable, and for which, she had consulted many, and used a multiplicity of remedies; many of them, no doubt, very appropriate for *pruritus*, but *not for her*. When she came under my care, I also, at first, adopted the wrong course; I prescribed *for the symptom*, and *not for its cause*. But fortunately, after seeing her a few times, something led me to suspect the existence of intestinal worms. I gave her a dose of the Kouso, which caused the expulsion of some very large lumbrici, and all her troubles were forthwith at an end.

Mrs. M. consulted me for *pruritus* of the pudendum, from which she suffered to such a degree, and it was accompanied with other symptoms of so distressing a kind, that she declared she loathed herself, and felt her life an intolerable burthen to her. She had used gallons of lotions, and all sorts of ointments, without the slightest relief. Examination showed an intense congestion of the cervix uteri; this was made the object of treatment, and on its removal, the *pruritus* and all its miserable concomitants totally ceased.

I have already called the consent between the uterus and bladder, a reciprocal sympathy, because it equally acts in the reverse direction, irritations of the bladder being frequently found to influence and disturb the functions of the uterus—a fact which should not be forgotten in practice, and especially in the treatment of the diseases of pregnancy, when the administration of the more irritating diuretics should be avoided, lest they should excite contraction of the fibres of the uterus, and so induce premature expulsion of its contents. That they are capable of so doing is, unfortunately, popularly known, and advantage is taken of such knowledge for base and wicked purposes.

And again, we must remember that vesical disturbances may produce a group of symptoms so closely resembling those arising from disease of the uterus, as to be mistaken for them.

Several years ago, there occurred in this city, a case forcibly illustrative of this, and which excited

no small sensation. The wife of a general officer, at that time holding the highest military command in this country, began to complain of distressing symptoms, having all the characters of those produced by uterine disease. Such was her own conviction, and on her consulting an accoucheur, then in large and high practice, her worst fears were confirmed; he pronounced the affection to be cancer uteri, and could only promise palliation. But she had many anxious friends, whose happy privilege it is always to hope for the best, and some of them urged upon her the necessity of having another opinion; to this, she at last consented, and the gentleman called in, pronounced the case to be one of stone in the bladder; the stone was extracted, and the lady passed at once from a state of pain and misery, to one of comfort and happiness.

A few years since, a patient came to consult me, stating that, to gratify her friends, she had come to town for my advice, although quite aware that she could not be cured. She also handed me a written statement of her case, which set forth that she had had seven labours of terrible severity, owing to contracted pelvis, always requiring instrumental delivery; that for some months she had exhibited unequivocal symptoms of the existence of cancer uteri; and I confess, that from this account, and the woman's own description of her symptoms, I thought there was little room for doubt as to the nature of her malady. However, I, of course, gave no opinion, and suspended my judgment until I should have instituted a careful examination; on doing so, I could discover no disease of the uterus, but the neck of the bladder was distended, and felt very hard. I passed a sound into it, which at once struck against a stone of considerable size. Mr. Fleming now saw the case with me, the stone was removed, and the woman soon returned home well, and continued so.

It is not my intention to enter into a lengthened exposition of all the details of this part of our subject, but only to ask the attention of this distinguished meeting for a few minutes, while I review as briefly as may be, some forms of disturbance of the functions of the bladder occurring at the time of labour. And I may just premise, that considering the frequency with which we witness such interchange of sympathies as we have been hitherto discussing, and their production, in many instances, from comparatively unimportant causes, we would anticipate from the close relation of juxtaposition between the uterus and bladder, and from the direct exposure of the latter organ to the powerful mechanical efforts of the uterus, as well as from the marvellous anatomical and physiological changes taking place in the latter, during pregnancy and parturition, and immediately after—we would, I say, be led to expect that the innervation and powers of the bladder would be likely to exhibit still more marked and decided evidences of impairment, or

some other abnormal condition, in the puerperal woman; and accordingly, in practice, we find that there are, at least, four forms of disturbance of the functions of the bladder, which are not unfrequently produced by parturition, even when that process is easy and natural:

1st.—Irritability, causing an inconveniently frequent desire to discharge its contents; and this with a certain amount of pain.

2nd.—Loss of expulsive power; the natural sensibility being unaffected.

3rd.—Total loss of the natural sensibility, or irritability, which prompts to the evacuation of the contents of the organ.

4th.—A peculiar form of hysterical retention.

The first two of these states require little more than to be glanced at; the third and fourth demand a somewhat more particular consideration.

1st.—The irritability of the bladder which succeeds labour, almost always, yields readily to soothing measures, such as warm anodyne fomentations, a linseed meal poultice, opiate and camphorated embrocations, an opiate suppository in the rectum, or the administration of the *Mist. Camphoræ c. Magnesii*, with Tincture of Hyoscyamus and Syrup of Poppy. Should there be reason for suspecting inflammation, it may be necessary to apply a few leeches, and use other appropriate remedies; but this is rarely the case.

2nd.—When the expulsive power is in abeyance, but the natural sensitive irritability remains unimpaired, the desire to evacuate the contents of the organ becomes distressingly urgent, in proportion to the amount of accumulation within it.

This condition is sometimes produced by pressure from the uterus happening to be larger or lower than usual, perhaps displaced, or from the presence of an uterine tumor, in which case, raising up the obstacle may remove all difficulty. Sometimes, merely permitting the patient to assume the sitting position may suffice. Should these plans not succeed, the introduction of the catheter gives the desired relief.

3rd.—Again, there is the third and most important variety, in which there is no irritability, not even the natural desire to evacuate the urine, nor sensation, nor consciousness of requiring to do so, although a large accumulation is taking place, which will soon produce symptoms, not alone very distressing in themselves, but, what is worse, conditions which may lead us greatly astray, and excite groundless apprehensions of great impending danger; and it will not lighten our discomfort, should it turn out, as has often happened, that the patient owes all her annoyance to our inadvertence, or to the carelessness of the nursetender; for if we are careful in making the requisite inquiries, and give the proper directions to the nurse, and she attend to them, the accident, of which I am about to speak, *could not happen*.

The first time I remember to have had my attention drawn to this condition was in the year

1832. and in the case of an esteemed medical friend's wife; who was delivered of her first child, after a natural labour of fifteen hours, presenting nothing unusual, if we except the most tremendous rigor I ever witnessed, which occurred shortly after delivery, and was so violent that I really thought it must have ended in convulsions; but simple means removed it, and she went on well. Before leaving her, I cautioned the nurse to encourage the lady to pass water in the course of the evening, as she had not done so for several hours; this, however, was neglected, as the lady neither expressed, nor felt any want; and, at my next visit, I found my patient very feverish, with headache; a pulse above 120; the belly tumid and tender to the touch. Before proceeding to introduce the catheter, of which she had a great horror, I advised her trying to pass water, which she did, to the amount of at least two quarts, with instant relief to all the symptoms. Her convalescence was uninterrupted.

At a time when there were occurring several cases of puerperal fever through town, a medical friend called on me to request that I would accompany him to visit a patient of his, who had been confined two days previously, after a severe and protracted labour. She was not going on well, and he thought he had to deal with a case of the above-mentioned formidable disease, as his patient was very feverish, had most distressing headache, a rapid pulse, with abdominal pain, swelling and tenderness. On seeing her, I thought the presence of a large quantity of fluid was beyond doubt; a catheter was introduced, and an enormous accumulation of urine withdrawn, with immediate and decided relief to all the symptoms. It was then ascertained, that she had not passed water since her confinement, nor for many hours before it; she recovered perfectly.

The next case occurred to me under circumstances which invested it with a very unusual interest, and caused it to make a great impression on me. I happened to be staying for a few days in a very fashionable watering-place in England, where there resided a family of great wealth and consideration in society; the eldest son of which, had married a lady of large fortune and high connexion. This lady had recently been confined of her first child; and, as may be readily supposed, the attendance upon her had been a matter of warm ambition among the local practitioners; and the gentleman who carried off the prize was, I fancy, more envied than congratulated by his confreres.

I met this gentleman accidentally in society, and the following morning he called on me in a state of painful agitation and distress; "I am," he said, "in a terrible dilemma, and fear I am a ruined man." He then proceeded to tell me that he had attended Mrs. — three days before; that she had rather a severe labour, and that at the end of thirty hours, finding the labour not likely

to terminate by the natural efforts, the head having remained stationary for several hours, low down in the pelvis, and pressed strongly against its floor, he had delivered her with the forceps, without, as he assured me, any difficulty whatever. All then seemed well, but next day, the lady was uncomfortable, restless, feverish, and rather larger than she ought to be, and this state went on increasing until the third or fourth day, when, to his horror, the urine began to trickle away incessantly, and a slough, about the size of a sixpence, was discharged from the vagina. He at once, naturally enough, concluded that a vesical fistula was established; and I, taking his account as my guide, thought there was but little doubt that his worst apprehensions would be realized.

At his urgent request, I accompanied him to visit the lady, whom I found with a hot skin, much headache, a very quick pulse, a very distended abdomen, which was moreover so tender that she could hardly bear it to be touched; but I distinctly ascertained the presence of fluid. On examining *per vaginam*, I could not detect by the finger any breach of surface along the anterior wall, or back of the bladder, and I suggested to Mr. — that it would be well to pass a catheter into the bladder; which, at his request, I did; and gave exit to a quantity of urine, sufficient nearly to fill an ordinary wash-hand basin. Subsidence of the abdominal swelling immediately took place, the lady felt inexpressible relief, and from this day went on well.

The truth was, that the bladder had been forgotten by all the parties concerned; and the patient had never passed water since her confinement, nor felt a desire to do so; until at last the bladder became so distended, that the resistance at its neck was overcome, and the urine leaked out at the front, as fast as it was pumped in from the ureters at the back; and it so happened that just as this began, a small slough had separated from the mucous membrane of the posterior wall of the vagina, which had been strongly pressed on by the head for several hours.

4th.—Another state, not exactly ranging under any of the former kinds, seems to be of a purely nervous or hysterical character, and mixed up with a certain amount of *mauvaise honte*. The patient has a decided desire to pass water, and suffers distress from its retention; but has, at the same time, the greatest reluctance to make the necessary effort, and *positively refuses to try, if any one, even the nurse-tender, is present*, declaring that it would be impossible for her to succeed.

Under those circumstances, suitable arrangements should be made by the nurse, and the patient then left by herself, for a time, during which she may succeed in accomplishing the desired object; if she does not, some anti-nervous medicine should be given, with strong assurances of its potency in removing such difficulties; let her try again during our absence, and if she has not succeeded when we come to pay our next visit, we

must declare that longer delay would be unsafe, that we will wait a little while in the drawing-room, and if she does not then succeed, that we must draw off the water before we leave the house; this generally ensures success.

In many of these cases they do not succeed, because they do not make the proper effort; and this, I believe, is oftentimes, simply because they cannot, and not always because they *do not choose*; this state of nervous inability ought to meet with much tender consideration. I may observe here, that I have never met with this peculiar form of affection, except in the higher grades of society, and almost always in women of a highly sensitive nervous temperament, some of them having experienced a similar difficulty before marriage, and also under ordinary circumstances distinct from pregnancy.

Now, is this state which I have just been attempting to describe, analogous to, or identical with another, which I have a few times met with in practice, and which may be thus described:—A lady in perfect health retires to her bedroom for the night, and before lying down to rest, attempts to make water, and finds she cannot—she is much surprised—goes to bed, and perhaps falls asleep; in the morning, she is in great distress, but still unable to empty the bladder, and now her pain is so great, she is compelled to seek for assistance—the catheter is introduced, and all her trouble is at an end; or, perhaps, for several days, its use continues to be required, and then all goes on as well as ever; but, in either case, no circumstance of general ill-health, or local derangement or displacement can be discovered. The woman, in fact, is otherwise quite well.

The year before last a married lady of a highly nervous temperament, so affected, drove six miles into town to my house, in great torture: I drew off the water, and she required no further assistance.

Last year, I was urgently summoned to see an equally nervous maiden lady similarly situated; on laying my hand on the abdomen, I felt a tumor, as large as a melon, and as hard as a cricket ball; and *per vaginam*, it really, at first, suggested the idea of a fibrous tumor of the uterus, this organ being quite displaced. I introduced the catheter, drew off a large accumulation of urine, and the abdominal tumor—which was nothing more than the distended bladder—at once disappeared. The feature in this case which particularly arrested my attention was, the extraordinary hardness and the distinct outline of the abdominal tumor, which would readily have caused it to be mistaken for a solid morbid growth.

I may here observe, that in the well-known case of the virgin mock prophetess, Joanna Southcott, there was felt, by competent judges, a circumscribed tumor in the abdomen, which was supposed to be the gravid uterus. Dr. Reece, in his published history of the case, says—"In that part

occupied by the womb, there was a firm circumscribed tumor as large as a man's head, bearing the shape of the womb; I have no doubt of its being an enlargement of that organ." But when she died, no tumor existed, and that which was felt during life was attributed to the prophetess having learned to retain the urine until the bladder became considerably distended; which seems highly probable.

In my case last related, it was necessary to relieve the lady every day for a week; when she perfectly regained the power of micturition. I may just mention, that the remedy which seemed to remove her inability was the ergot of rye; did it do so by stimulating the fibres of the uterus in the first instance, and then, by consent, those of the bladder? Perhaps so; but as the same agent has produced a similar effect in men, a direct influence may be equally admitted.

RICHMOND, WHITWORTH, AND HARD- WICKE HOSPITALS.

CLINICAL LECTURE.

By DR. CORRIGAN,

Physician in Ordinary to the Queen in Ireland, &c. &c.
(November 18, 1857.)

Glandular Tumors of Pelvis; their nature and treatment.—Typhus and Typhoid Fevers distinct diseases; peculiar eruptions of, as diagnostic signs.

The first case to which I desire to draw your attention is that of Margaret Kennedy, who was admitted on the 6th October, 1857. She is now able to be out every day. The history of the case is:—She has been married seventeen years, and has had three children; seven years have elapsed since the birth of the last child. Her catamenia continued regular until within about fourteen weeks since, when they did not appear for seven weeks, during which time she thought herself pregnant. At the end of those seven weeks—and about seven weeks since—she was seized with acute pain in the abdominal region, which soon became so very severe and continued, as to make her seek relief in hospital. On examination, we found on each side of the abdomen a number of tumors, some lying close to Poupart's ligaments, others extending on either side into the abdomen. They felt hard and were tender under pressure, as was also the peritoneum in both iliac regions. She suffered also occasionally from retention of urine.

On the 1st November we found, at our morning visit, as you may recollect, that she had suffered very much during the previous night. She was lying in bed on her back, very sunken, with the abdomen very tumid, particularly in both iliac regions, and complaining bitterly of pain.

The region of the bladder was dull on percussion, but not tense, and the nurse said that urine had been passed freely during the night in the bed. Let me dwell a little on the case here. No tense swelling over bladder—bed wet with quantity of urine passed during the night—while the dulness on percussion, might have been supposed to depend on tumors, or an effusion into the peritoneum. Do not let these symptoms mislead you to overlook examination of the bladder, and do not expect that in such a case you are to feel a bladder tense as you will in recent obstruction from stricture. In the state of the bladder with which we had to deal on that morning, the urine that passed into the bed was merely the overplus. The bladder had utterly lost its contractile power, and it held a large quantity of urine like a flaccid bag. On introducing the catheter, about two quarts of urine were drawn off. The same state of bladder will frequently occur in low fevers; a dribble of urine constantly going on into the bed-clothes, while the bladder lies like a flaccid bag containing a very large quantity, and making no effort to expel it, and giving to the hand no sensation of a distended organ. If the region of the bladder be dull on percussion, use the catheter; do not wait for feeling of tense distension; immediate relief follows the use of the catheter. Kennedy's case is an illustration of a disease which we meet with both in the upper and lower classes of society. The tumors sometimes disappear by resolution; in other instances they suppurate, open into the vagina or rectum, or occasionally present themselves in the iliac region on either side, and then frequently resemble hernia. This resemblance is increased by their receiving an impulse from coughing, and when they rise from the inner pelvis, and that their contained matter has lain close to the rectum, they will discharge air and excessively offensive matter mingled together, leading one at first to suppose that an intestine has been opened. We have now to inquire into the nature of those painful tumors, sometimes attaining a great size and prominence in a few weeks, very painful, and involving, occasionally, great risk to life for a time. They generally terminate favourably if their nature be remembered and their progress carefully watched. These tumors consist of glands taking on an inflammatory action and swelling—either the deep-seated glands within the true pelvis, or the more superficial, lying in the same sheath of cellular tissue with the external iliac artery and veins, or both groups of glands together. In investigating medical diseases, bear in mind medical anatomy.

In the present instance you must recollect that the uterus is steadied in its place by what is called the broad ligament at each side, which you know is only a fold of peritoneum. You must also recollect that where the folds of peritoneum from the uterus reach on each side the inner side of the pelvis, they turn backwards towards the sacrum, and anteriorly towards the pelvis, leaving

between them a triangular space, in which lie a number of lymphatic glands connected with the absorbents of the uterus, and these lymphatic glands, enlarged and inflamed, constitute, in part or in whole, the tumors in cases like that now before us. I will now draw your attention to another diagnostic point in the case. I repeatedly and carefully cross-examined Kennedy as to the duration of her attack, and she always and repeatedly said that it was only of the duration of a few weeks. This statement was a material element in the diagnosis, for were the case one of ovarian disease, the growth of the tumors would not have been so rapid.

Having dwelt so long on the nature of the disease, we have now to turn our attention to the treatment. Dr. M'Dowel had the case in his care for some days previously to my taking charge of the ward, and I had merely to follow up the line of treatment he had instituted. The exhibition of mercury pushed to produce salivation; of opium, to allay pain; of blisters to abdomen, followed by cataplasms smeared with mercurial ointment, and attention to state of bladder. Kennedy's case has been one of sub-acute inflammation, and has gone on rapidly and favourably; but a case of a similar kind, but more chronic in character, will extend over many months, requiring constant and anxious care, and terminating favourably. They are cases that require incessant, almost wearisome attention to minute details of treatment, and caution as to avoidance of jolting in rough carriages, of much exercise, of all stimulants, &c. After months, or even years, the tumors I have described will disappear. These tumors must not be confounded with ovarian diseases; they will not only not interfere with pregnancy, but they will disappear under the influence of pregnancy.

I shall next draw your attention to a case in the Hardwicke Hospital. It is a case illustrative of a question exciting now very great interest—namely, the difference between typhus and typhoid fever, as to whether they are distinct diseases, or merely varieties of the same disease arising from the same poison. The case is that of a man named Dixon, aged 36, admitted into the Hardwicke Hospital on the 9th November. He was then nine days ill; he is now, therefore, twenty-seven days ill; he is recovering, but his amendment is slow, day by day. He lies on his back, in a state of prostration, and his pulse is about 116, weak and soft. My principal object in now noticing this case is, that you may recognize the specific eruption of the disease. In four or five days after his admission, when about thirteen days ill, I asked you to observe two or three little spots on the skin over the region of the cæcum. They were oval in shape, very small, of a light rose colour or pink; when you placed your finger on them, you felt they were elevated above the surface—that they were, in fact, papules—and on pressure their colour

disappeared, showing that the blood to which they owed their colour was still contained in vessels. They continued daily to increase in number, and to-day, the twenty-seventh day of his illness, they are in great numbers, thickly scattered over abdomen, iliac, and lumbar regions, extending into the spinal lumbar region.

I cannot refrain from thinking that the mind may be naturally, although unconsciously, led to consider the disease of Dixon—the case now before us—typhoid fever, as only a variety of “typhus fever,” from the mere circumstance of the phrase “typhoid” applied to it. In this country we affix the term “typhoid” to any disease that has coupled with it want of strength or enfeebled circulation. Thus, we constantly speak of “typhoid” erysipelas; “typhoid” scarlatina; “typhoid” pneumonia. The phrase, however, has not this loose meaning in correct pathological nomenclature. When applied to Dixon’s case—the title means a local disease of the glands of the intestines—as distinct a local disease as any other with which we are acquainted, and is synonymous with “acute follicular enteritis,” or “dothin-enteritis.” Keep this clearly in your mind, and then examine for yourselves, whether Dixon’s case can be merely a variety of typhus fever, or whether it ought to be regarded as a peculiar distinct disease. I can have no hesitation in expressing my opinion in favour of the latter. In *Lectures on Fever*, published in 1853, I advocated this view, and I adhere to it. For my reasons at length, I must refer you to them—I shall here only deal with the eruption. The eruptions that we see in typhus fever, and in acute follicular enteritis, are three in number, and I would ask you to keep this clearly in mind.

1st.—The true typhus macule, which is a stigma consisting of merely distended capillaries in greater or less numbers, and of various shades of red or dark red, according to the degree of the stasis in the circulation, not elevated, but flat as the skin, and of no regular shape; it is from the great number of these that the skin in true typhus fever derives its remarkable mottling. That these maculæ are merely stigmata of distended capillaries, the blood remaining still within the vessels, is evident from this, that pressure with the tip of the finger makes the maculæ disappear for the moment, by pressing the blood out of the vessels. This is the peculiar eruption of true typhus.

2nd.—Petechiæ, or petechial eruption. Petechiæ are spots or specks, always of a dark colour. They will not disappear under the pressure, for the blood in them is effused into the tissues of the skin. They are not peculiar to typhus fever, but may be seen in low cases of variola, scarlatina, and measles, and may accompany the lenticular eruption of typhoid fever, and they constitute one of the constant phenomena of purpura. They always indicate a morbid state of the blood, and a low state of vital energy; and hence, when present in typhus fever, mixed with maculæ, they indicate

a very severe form of the disease, “typhus gravior.”

3rd.—Lenticular, or papular eruption of follicular enteritis, or “Typhoid Fever.”

I have already described the characters of this eruption, and I need not now repeat them. I made all these distinctions as I now give them, in the *Lectures on Fever* published four years ago, and I see no reason to depart from them. In the course of the session, judge for yourselves whether typhus fever, with its maculæ, and typhoid fever, or follicular enteritis, are two distinct diseases. But it may be said, they are the results of the same morbid poison, and therefore more or less merely varieties of the same disease. This is in my mind a point of no particular importance. If it were asserted, or even proved, that measles and scarlatina were the result of the same morbid poison, it would not the less oblige us to consider them as diseases distinct in their nature, in their progress, and their treatment; and if it even were admitted, what never can be proved, that typhus fever and follicular enteritis (or typhoid fever) were the result of the same morbid poison, it would not in the least affect the practical question, that they are two diseases, different in their progress, their symptoms, their pathology, and their treatment.

We shall have sufficient opportunities in the course of the session, for again taking up the subject of fever.

CASE OF PHTHISIS,

IN WHICH A LARGE OPENING FORMED IN THE THORACIC PARIETES, COMMUNICATING WITH A FISTULOUS OPENING IN THE LUNG, ETC.

By M. C. BERNARD, M.B.T.C.D., L.R.C.S.I.,
Surgeon to the Dundrum Dispensary, Co. Dublin.

Mr. —, aged 24 years, has been under my care for the last two years. Before his illness he was active and energetic in his habits, and was a young man of great promise, having exhibited much talent in passing through the Dublin University. Although the symptoms of delicacy, which were early developed, may be considered attributable in a great measure to his studious habits, to his sitting up till late hours and robbing himself of his nights’ rest, I may mention that he had an hereditary predisposition to phthisis, and that his father and two brothers died of consumption. I attended the two latter during a long illness; there were no symptoms in either case, however, worthy of particular note.

In order that I may state this case as briefly as possible, it will be merely necessary to say, that the symptoms under which my patient laboured during his protracted illness were nearly similar to those which are generally observed in ordinary cases of phthisis; he had hurried breathing, troublesome cough, with copious expect-

toration of flocculent muco-purulent matter, loss of flesh, strength and energy. He had two or three attacks of hæmoptysis, which were combated in every instance by large doses of gallic acid, to which small doses of spirits of turpentine were occasionally added with benefit. I may add, that the physical signs elicited by percussion and the stethoscope differed in no important features from those which are ordinarily observed in cases where tubercular deposits, softening, and cavities unquestionably exist. It is sufficient for our purpose here to say, that at the end of July last—when an extraordinary and unforeseen change in his symptoms took place—he had all the symptoms of a person far advanced in the third stage of pulmonary consumption; he had not only a large cavity in the upper part of the right lung, but the remainder of this viscus was studded with tubercles throughout, while signs of softened tubercle existed to a great extent in the left lung.

Whilst labouring under these symptoms, and about the time above specified, my patient drew my attention to a distressing sensation at the upper part of his chest. He told me that whenever he took a full inspiration, or had a severe fit of coughing, he heard a loud noise or crack in this part of the chest. Upon examination, I found that in the situation corresponding to the junction of the second rib with the sternum on the right side, the integuments were raised, thinned, and presented an erythematous blush about the size of a shilling. Upon pressing this part, I felt a distinct crepitus; likewise when my patient drew in a full breath, a sound similar to the crepitus of a fractured bone was distinctly heard. The integuments from this time got thinner daily, until at length they gave way, and the end of the rib protruded and filled up the opening. After a week's time the aperture increased in size, from the retraction of the surrounding integuments, until it became of an oval shape, and about one inch by one inch and a-half in dimensions.

August 15th.—My notes state:—The protruding rib now floats loosely, and is seen covered with granulations; its extremity is rough to the touch. Having lost its connection with the sternum, and consequently having no support, it rises and falls during inspiration and expiration. Inasmuch, however, as the rib does not fill up more than one-third of the dimensions of the aperture, a full view into the cavity of the chest is admissible, and the lung can be distinctly seen, for a great extent, in the depth of the hiatus.

To understand the appearances existing at so great a distance from the external opening, we must remember that a cavity was diagnosed in this situation, and that its walls are now found collapsed by the pressure of the atmosphere admitted through this abnormal aperture; the space thus left between the collapsed lung and the anterior

wall of the chest, may be estimated as capable of containing a middle sized orange.

A fistulous opening is also observed to proceed from the upper part of the pulmonary cavity, from which purulent matter is seen to exude; this matter is most probably kept from gravitating to the lower part of the pleural sac by adhesions of lymph, which glue the pulmonary to the costal pleura in this situation. This adhesion is also proved to exist by the stethoscopic sign of cavernous respiration heard below the edges of the aperture. When the external orifice is left uncovered for any length of time, the patient suffers the greatest distress: he can neither speak nor cough, for reasons too obvious to mention; indeed, he rarely attempts to speak without pressing the left hand firmly upon the opening; both inspiration and expiration take place through the fistulous opening at this particular time. It is worthy of remark, that the lung appears to recede from the side towards the mediastinum during the act of inspiration, and again comes forward during expiration, and that the dressing laid upon the opening is drawn in during inspiration. The stethoscopic phenomena may be said to be similar to those of a large cavity; when the stethoscope is placed over the dressing, the sounds heard are those of gurgling and metallic tinkling.

These remarkable appearances can be but very imperfectly described, and must be seen to be fully understood. I am happy that they were witnessed upon one occasion by Dr. Stokes, and then, and several times since, by my friend Dr. Hudson, who had repeatedly seen the case with me at its earlier stages.

The treatment pursued has been simply to maintain the closure of the external opening, by a dressing of lint covered with gutta percha sheeting, rendered air tight by painting the edges with a solution of gutta percha in chloroform.

Another phenomenon worthy of remark, was observed about a week or ten days previous to our patient's death. The union between the different component parts of the sternum, seemed to be severed, as also the union between the cartilages of the ribs, on the left side with the sternum; on pressure being made over these articulations, a sensation was communicated to the fingers, as well as to the ear, similar in every respect to that already described, as preceding the appearance of the erythematous blush, the absorption of the integuments, and the abnormal opening into the thoracic cavity.

Our patient, as may be anticipated, suffered much during the fortnight before his death, which event took place on the 26th of September last. He had two or three attacks of an epileptic character, during that short period, and had violent paroxysms of dyspnoea, which was for the most part caused by the great difficulty of expectoration.

STEEVENS' HOSPITAL.

ABSTRACT OF

AN INTRODUCTORY LECTURE.

By S. L. HARDY, M.D., F.R.C.S.I., L.K. & Q.C.P.

Physician Accoucheur to Steevens' Hospital, and Lecturer on Midwifery, &c., in the Medical School of the Hospital.

Dr. Hardy commenced by congratulating his audience on the establishment of a Chair of Midwifery in Steevens' Hospital, and the newly founded School of Medicine in connexion with it. It was, perhaps, the only *school* in Dublin in which Midwifery was *clinically* taught. In this Institution they had the advantage of the course of lectures on the theory and practice of Midwifery, which were delivered in the *school*, being illustrated by the cases which were daily submitted to their notice in the adjoining *hospital*. He then proceeded to compare the rude state of the obstetric art in regions not yet civilized, with the excellence of obstetric medicine in those countries which have reached a high standard of civilization. Among other instances of the former, he quoted from the *Indian Journal of Medical Science*, the following picture of midwifery practice as it exists at present in the Burman Empire:—*

"About the seventh month of pregnancy a Burmese woman is advised to tie her petticoat more tightly, and lower round the body, just above the fœtus, in order to force and keep it down as low as possible, and prevent its ascending, which if it did, would afterwards, it is supposed, render delivery more tedious and difficult. When the labour pains come on, the woman is attended by one or two midwives, and by three, four, five, or even six of her female relatives or friends, who shut all the doors and windows of the room, so as to render it as close and hot as possible. She is in a state of perfect nudity, and being urged to take violent exercise, runs round the room as long as she is able, with or without the assistance of her friends—sometimes stopping and pressing her loins against the posts of the house, sometimes raising a heavy weight with both her hands, and then forcibly bringing it down, as if pounding, and sometimes falling down and rolling on the floor. In her distraction she sometimes grossly abuses her husband, who is not admitted near her, but generally sits in the next room or in the street, laughing on hearing himself abused; or if he possesses more feeling, he opens and lifts up the lid of every box in his house, as a preventive against any charm that may have been used by any evil-disposed person, and prepares some charmed or holy water, which he sends in to his wife to drink.

"The woman's body is smeared with oil, and her

attendants press down the child violently with their hands, urge her to strain, and sometimes put up a foot against her loins and press against her, holding her arms back. At last the woman is quite exhausted and falls on the floor, some of the women still keep pressing the child down with their hands, trying to expel it forcibly; and in some instances the woman is placed on her back, and the midwife sits upon her, or stands up and presses against the child with one of her feet.

"When the child is born it is still kept near the mother until the after-birth comes away; to produce which the attendants again press the abdomen of the woman, pull the navel cord, and sometimes beat her loins with a hard pillow, and force a portion of her long hair down her throat, in order to create an inclination to vomit.

"As soon as the after-birth appears, the navel string is cut, and the child taken charge of by one attendant, while four others, one to each arm and leg of the woman, take her up, bathe her in warm water, and lay her as close as possible to a large fire. A hot brick and salt enveloped in a cloth, are also pressed against different parts of her body in succession, and often a handful of warm salt is applied and even introduced.

"The woman is subjected to this process of *roasting*, as the Burmese women themselves call it, for seven days, during which time, and often for a longer period, she is obliged, three times a day, to take a dose of salt and turmeric, in order, as they say, to keep the inside of the body as hot as the outside; to drink warm water when thirsty, and to use a vapour bath. She is kept lying on a narrow bamboo frame, raised a few inches above the ground and only a cubit wide, placed as close as possible to the fire, so that she can only just turn from side to side, with her back and stomach to the heat, as she finds it too great.

"A lady of rank, during these seven days, is known to have burned so many as eleven hundred large billets of firewood; but the usual allowance is two or three hundred. The wood of the tamarind tree is used by those who can afford the expense, because it is said to make the hottest fire.

"Owing to the difficulty of shutting out draughts of air from a Burmese house, the woman often catches cold during this roasting process, and in consequence often suffers afterwards from rheumatic affections, and often troublesome and tedious disorders; and whenever such cases of illness occur, the Burmese say that they are owing to the woman not having been roasted enough. A woman speaking to a medical man, will tell him, that since her last *roasting* she has suffered so and so; or, that it is now four months since was roasted.

"Some, however, regard these days with great disapprobation and horror. The principal midwife, a woman who has been in active practice for fifty years, estimates the mortality so high as ten per cent., which, however, appears much too high an estimate.

* This practice was witnessed by Dr. Howard Montgomery, Professor of Materia Medica and Medical Botany, who was formerly a pupil of Steevens' Hospital.

"The diet, after delivery, is so hot and pungent as to make the woman wink, and her eyes run with water.

"The mother is not supposed to have any milk for her infant until after the third day; and to produce the secretion, her breasts are rubbed and fomented with warm water, and the nipples pulled and scraped with the nails of her attendants."

From this the lecturer passed to a review of the state of midwifery in Ireland in early times, (in which he borrowed largely from Dr. Wilde's researches,) when midwifery, according to the old definition, was declared to be only the "art of assisting women in labour."

At the present day, the practitioner in midwifery, in addition to a thorough knowledge of all the varieties of labour and the casualties with which they may be complicated, is expected to be familiar, not only with the anatomy of the uterus in its virgin and gravid states, but with its physiological laws also; with the diseases to which it is subject; with the nature of the organised products which may form within it; with the symptoms which indicate the existence of pregnancy, and the laws that regulate gestation and its duration; the characters by which the age of the fœtus may be determined, and the many and important diseases of childbed and early infancy: the treatment of which is to be learned but in one way, and that is, by acquiring first a thorough knowledge of anatomy and physiology, especially as regards the female system, and then such an acquaintance with the general practice of medicine as will enable us to apply its principles to those particular cases, with the peculiarities of which our frequent observation of all the circumstances of the puerperal woman has made us thoroughly familiar.

The first and most decided step taken to improve the midwifery practice of this country, was by Dr. Bartholomew Mosse. He had been employed by government in the year 1738, to take charge of the men drafted from Ireland to complete the regiments in Minorca. Before and after this appointment, he had practised surgery and midwifery with success; but, as he stated in a paper which he afterwards published, "intending to perfect himself in surgery and midwifery, he travelled into England, France, and Holland, and several other places of Europe; and that from his first entrance into such study and profession, he became convinced of the great usefulness, if not necessity, of having an hospital for lying-in women in the city of Dublin." Dr. Mosse carried out his intention, first by opening an hospital in South Great George's-street, on the 15th of March, 1745, and afterwards by the erection of the present Lying-in hospital in Rutland-square, which, on the 8th of next December, will be one hundred years in operation as a school of midwifery. Of this hospital, Dr. Mosse was the first master, and was succeeded by the celebrated Sir Fielding Oulde, whose description of the manner in which the head of a child passes through

the pelvis during labour, has been so exceedingly accurate, that all who have since written on the mechanism of natural labour, have but amplified and improved the explanation given by him, or raised a superstructure on the great foundation which he laid.

The Observations on Midwifery, by Dr. William Dease, a surgeon of great eminence in this city, published in 1783, are most valuable, particularly his remarks upon the similarity that exists between puerperal fever and that which frequently arises after surgical operations.

To Dr. Joseph Clarke, who was elected master of the Lying-in hospital, in November, 1786, belongs the credit of a discovery which has saved the lives of thousands of infants. Before this discovery, we are told that "for the first twenty-five years the institution was open, nearly every sixth child died" of convulsions, or what is commonly termed nine-day fits, as occurring within the first nine days after birth. The necessity of ventilating the wards freely, was pointed out to the Governors of the hospital by Dr. Clarke, who adopted his improvement; the result was, that instead of the enormous mortality of one infant out of every six, of eighteen thousand and thirty-three children, born subsequently to the wards being ventilated, only about one in 19½ died. This was the report made by Dr. Clarke, six years after, to the Royal Irish Academy.*

He was the first to publish a report of the hospital, which appeared in the first volume of the Transactions of the King and Queen's College of Physicians. The value of Dr. Clarke's report of the hospital was greatly enhanced by the publication of his record of private practice, by Dr. Collins; thereby enabling an estimate to be formed of the results obtained from two very different sources of midwifery practice. Of Dr. Clarke's hospital reports, there are 10,378, and of his private practice, 3,847 cases.

To Dr. Douglass, formerly Assistant-Physician to the Lying-in Hospital, we are indebted for a correct and accurate description of the mechanism of spontaneous evolution of the fœtus in arm presentations, which he observed in 1810, and published in 1811, under the title, "An explanation of the real progress of spontaneous evolution of the Fœtus." A second edition of this book appeared in 1819, with a very complimentary letter from Dr. Denman to Dr. Douglass on his discovery; and in 1844 the third and last edition.

The next report of the Lying-in Hospital was contained in the "Practical Treatise on Midwifery," by Dr. Collins, giving the result of 16,654 births. It was during the mastership of Dr. Collins that the great value of auscultation in cases of labour was fully established. Dr. Evory Kennedy investigated this subject with great industry and care, and showed its importance, not only in midwifery

but in medico-legal inquiries. His work on auscultation appeared in 1833. In 1838 he founded the Obstetrical Society, for promoting the improvement of Midwifery. It is now nearly twenty years since it was established; during this time it has been the source from which many valuable communications have emanated on midwifery and the diseases of women and children.

The third and last report of the Lying-in Hospital appeared in 1848, under the title of "Practical Observations on Midwifery and the Diseases incident to the Puerperal state," by Dr. M'Clintock and myself. It contains an account of 6,634 deliveries, and may be "regarded as a faithful exposition of the practice of the hospital under (Dr. Johnson) one of its most experienced masters." I am happy to say there is at present going through the press the fourth report of the Lying-in Hospital, by Drs. George Johnston and Sinclair, formerly the Assistant-Physicians. This will contain the records of a very large number of cases which occurred during the mastership of Dr. Shekleton.

None have done more—few so much—to elevate the name and reputation of the Dublin School of Medicine, as the late Professor of Midwifery in the King and Queen's College of Physicians. During the thirty years that Dr. Montgomery so efficiently and ably filled that chair, his time and talents were diligently and zealously occupied in the performance of its arduous duties; and when at length it became necessary for him to devote more time to his private professional engagements, he took leave of his public appointment by a farewell course of six lectures, on that most interesting and important subject, Ovology; having previously placed in the hands of the profession the second edition of his work on the "Signs and Symptoms of Pregnancy."

Upon the merits of this work it is not for me to expatiate; I prefer in noticing it to quote simply the words of an English periodical, the *Lancet*, for April 4th, 1857:—

"It will long remain the standard work and authority upon the subject of which it treats. As a classical work, rich in facts, clear and logical in arrangement, sound in argument, modest and attractive in style, it will ever remain a solid monument to the reputation of the brightest ornament of the great Irish School of Obstetrics!"

In Dr. Churchill, the present professor who now occupies the Chair of Midwifery, we have a most industrious, active, and indefatigable member of the profession, whose name is well known, both at home and abroad, for the number, variety, and excellence of his writings.

To the cultivation of statistical records on Midwifery, much of the improvement in modern practice may be attributed. In each of the reports of the Dublin Lying-in Hospital, great care was devoted to this subject. By being enabled to compare the results of our practice at home with

that in other countries, these advantages are increased. An opportunity for making such a comparison upon a very extensive scale, was afforded by the very large statistics detailed of the Vienna Lying-in Hospital by Mr. Wilde, in his work on "Austria and its Institutions." This report contains the results of 25,906 deliveries, and is well deserving of the perusal of every practitioner in Midwifery; to which I would add the remarks upon the puerperal fever of the Dublin Lying-in Hospital, and the tables of deaths "by years, seasons, and diseases," contained in the Census for Ireland for the year 1851, "from the 6th of June, 1841, to the 30th of March, 1851."

Equal in importance with statistics is the formation of midwifery museums. This valuable means of becoming practically acquainted with uterine pathology, and the varieties and peculiarities of the fœtus, was commenced in 1824, by Dr. Montgomery. The museum which still bears his name, and is universally acknowledged as the most complete collection of its kind, has been transferred from the King and Queen's College of Physicians in Dublin, to the Queen's College in Galway.

The museum of the Lying-in Hospital was begun by Dr. Collins during his mastership, and has since then been increased by additions from the several succeeding masters; several others are now progressing in connexion with the midwifery institutions in Dublin.

Before you is arranged, under its several heads of midwifery, diseases of women, and diseases of children, the nucleus of what I trust will become one of the largest and best to be found in this or in any other country. Even on this, the birthday of our midwifery chair, the collection is far from being inconsiderable. From the abundant sources afforded by this large hospital, and from its many former and present pupils, who will forward their contributions from every quarter of the world, in a very short time the museum of this school will present an appearance, in its several departments of medicine, surgery and midwifery, worthy of the name of the great founder of this hospital, Dr. Steevens. (Dr. Hardy here made allusion to "Some account of Richard Steevens, M.D., and his Hospital," by Mr. Wilde, in the *Medical Times and Gazette* for December 6th, 1856.)

Time would not permit of my speaking of the many improvements in the treatment of female diseases; I shall merely allude to those for polypi, and vesicco-vaginal fistula.

The ligature, as used by Dr. Gooch, was of the greatest value, and is still employed in the removal of polypi; but owing to the time required, in some instances, for the morbid growth to slough off, irritative fever is sometimes produced. To avoid this delay several plans for speedy removal have been introduced. Dr. O'Grady, of Malahide, invented a forceps, having at its ends chambers for containing nitrate of silver; with this instrument

he is able to compress the root of the polypus, while the caustic destroys its vessels and prevents the danger to be apprehended from hæmorrhage. The Ecraseur is another method; by it the vessels are lacerated by powerful compression with a similar result.

The operation for the cure of vesico-vaginal fistula may be considered as one of the greatest achievements in modern surgery. An account of it, by Dr. Maurice Collis, its inventor, may be seen in the *Dublin Quarterly Journal* for August 1856, and by Dr. Sawyer, in the DUBLIN HOSPITAL GAZETTE for March, 1857.

Inseparable from midwifery and the diseases of women are the diseases of children. By the exertions of Sir H. Marsh and Dr. Johnson, an institution for the treatment of the diseases of children was established in this city in 1822, and was conducted by them for many years. Since its foundation it has afforded not only relief to suffering infancy and childhood, but has proved a valuable means for the student to acquire a practical knowledge of this branch of medicine.

The institution is daily attended by my colleague Dr. Moore, and myself, and is now increased in its usefulness, by including with the diseases of children those also of women.

That infantile diseases are inseparable from the practice of midwifery may be easily understood by reference to the examples which I here point out. The first is, disease communicated by the parent; the second, spontaneous amputation of the limbs; and the third, wounds; all occurring during intra-uterine existence, and consequently demanding the particular attention of the obstetrician.

Gentlemen, every day's experience makes our opinions the tribunal before which are decided questions that touch the dearest and holiest ties that hallow our social relations—the fair fame of purity and virtue, the fidelity of married life, the claim to legitimacy, and, as a consequence, the succession to wealth and honorable title. And in some instances connected with judicial investigations, as in cases of *clandestine delivery*, suspicions of *infanticide*, or in pleas in *bar of execution*, when a woman condemned to death, pleads pregnancy to save her from execution, life itself may depend on the accuracy of our judgment.

In undertaking the responsible duties of teacher on Midwifery, let me say:—

“Content if hence the unlearned their wants may view;

The learned reflect on what before they knew.

Averse alike to flatter or offend;

Not free from faults, nor yet too vain to mend.”

Dr. Brown-Séquard has issued a prospectus of a new *Quarterly Journal of Physiology*. He proposes to furnish a full account of the principal original labours of French Physiologists, and an historical *résumé* of physiological progress in other countries. He will receive the assistance of several distinguished observers in Germany, America, and Great Britain.

HEPATITIS IN THE TROPICS.

CASE I.—*Metritis caused by obstruction to the Vena Portæ.*

CASE II.—*Opening of an Hepatic Abscess into the Pericardium.*

By Dr. GERARD VÁN ARCKËN.

Merida, Republic of Venezuela, South America.

Hepatitis is no doubt the most common disease within the tropics. An elevated temperature operates as a direct stimulus upon the liver, and predisposes it to inflammatory action. The lungs are unable to eliminate the excess of carbon from the system, and the liver is called into increased action, for the purpose of assisting the lungs.—Acute hepatitis in this country (48° north of the equator) is hardly ever fatal; but the disease which annually carries off at least half the number of those that die, is chronic hepatitis, which either proceeds to induration, or to suppuration forming enormous abscesses. About two years ago I was present at a *post-mortem* examination, in which an abscess containing three pounds and seven ounces of reddish pus was found in the liver. The patient had died of acute dysentery, and his attending physician never suspected that his patient had a liver complaint.

It is almost impossible to imagine under how many different forms chronic hepatitis will show itself, as if trying to avoid the searching eye of the practitioner.

Some time ago I successfully treated a case of chronic metritis, attended with great discharge, of four years standing. I knew that all the common remedies and local astringents had been used without success. Making a minute examination, I found the liver somewhat tender to the slightest pressure. Upon this I applied a mercurial plaster to the right hypochondrium, and gave for three weeks in succession every other night, three grains each of blue pill and rhubarb. At the end of three weeks all the symptoms of metritis had disappeared; very abundant dark green stools occurred, and now, five months afterwards, the patient has not had the slightest return of disease.

The cause of the metritis in this case was the obstructed circulation through the vena portæ, induced by the condition of the liver and the subsequent retention of the bile.

A much more extraordinary case came under my notice last week:—A lawyer, 26 years of age, and of a robust and taintless constitution, was attacked, after a “*heavy supper*,” with what was considered a bilious fever. At the end of two weeks he was able to go about again; but still suffered occasionally from either indigestion or a slight diarrhœa, evidently of a bilious character. He then went travelling about for four months, but returned worse than he left; one physician after another was called in, but as none could relieve

him, and his family became alarmed, a consultation was called.

Various opinions were brought forward by native practitioners; one believing the case to be "*all stomach*," and another that there was a cancer situated in the curvature made by the ascending and transverse colon. After a careful examination I came to this conclusion, that it was an abscess, situated in the concave and upper part of the liver. But no other symptom of disease could be discovered; the lungs and heart appeared sound, and no abnormal murmur could be made out; the tongue was clean, there was no headache present; the pulse was 90, and almost natural. My opinion was corroborated by one physician, but being in the minority, we had to retire.

Still, as the patient did not get better under the new treatment, I was again called in, together with the physician with whom I had agreed. We again examined this patient carefully, but not the least symptom of any lesion of the thoracic organs could be discovered.

The abscess being situated too internally for admitting a hope of opening it from without, we determined upon giving two drastic purges, composed of blue pill, extract of colocynth, and croton oil, with the object of assisting nature, if she should, as might be supposed, already have formed adhesions for the purpose of evacuating the fluid.

The first purge produced only two natural stools; but the second brought away at first a liquid having all the appearances of water, with a few drops of fatty matter floating in it, and then a great number of stools, containing four or five pounds of pure pus.

This happened in the night, and the next morning we were of course delighted with our success, and the patient said, that "he felt like new born; and was hungry enough to eat half-a-dozen of roast chickens."

We allowed him two ounces of roast meat, one ounce of toasted bread, and half-a-cup of chocolate.

After having breakfasted, he asked for a small paper cigar, smoked it with apparent delight, spoke with some of his friends about his plantation; and at mid-day, complaining of sleep, asked permission to sleep three hours, which was granted.

At four o'clock we called again, and found the neighbourhood in the greatest consternation. A short time previous some friends of the family had called on them; they wished to see our patient—one of them withdrew the curtains, and he was found dead.

What was the cause of this sad death?

Commencing the examination from below, we found the intestines without any trace of disease, and the spleen healthy. In the ileum we found a small quantity of pus, mixed with the remains of his breakfast. But about one inch from the pylo-

rus the duodenum adhered firmly to the liver. Here was an opening large enough to admit a finger, through which the pus had escaped. But there was no sign of active inflammation around the opening; the liver, which contained an empty cavity, large enough to admit the head of a full-grown fœtus, appeared otherwise perfectly healthy, and the gall-bladder contained healthy bile. What was it, then, that carried off the patient so suddenly?

The liver adhered firmly to the diaphragm, the diaphragm to the pericardium, and through this adhesion was a tortuous channel, about the size of a goose quill, through which a part of the pus had entered the pericardium, while a clot of half-organised blood had cut off the communication by becoming wedged firmly in the channel. The lungs were sound, and so was the substance of the heart; but in the pericardium was found about two ounces of pus, adhering firmly to it, and of the consistency of fresh cheese. The pericardium was very much inflamed, altered in structure, and covered with exudations of all kinds.

I at first imagined that death occurred in this case as in that of Dr. W. Stokes, of Dublin, as mentioned in his work on diseases of the heart and aorta, from *pneumo-pericarditis*; supposing the air to have entered from the stomach through the abscess and together with the pus to the pericardium. But the clot found in the channel and shutting it hermetically, does not allow such a supposition in the present instance.

Besides, the opening into the pericardium was undoubtedly old, and probably happened long before the abscess opened into the duodenum, consequently no air could have entered.

Of what then did the patient die?

The inflammation of the pericardium and the pus adhering to it may have produced a sudden paralysis of the heart, in consequence of which a pseudo or real apoplexy took place, followed by death. The vessels of the brain were found highly congested.

I have never heard or read of a case of hepatitis, with formation of an abscess opening into the pericardium, and masking all the symptoms of pericarditis so completely. It is remarkable, too, that neither auscultation nor percussion betrayed in the least, the presence of a fluid in the pericardium.

[The absence of frottement in this case may be explained by the lubricating effect of pus in the pericardium, noticed long since by Dr. Mayne, in his *Researches on Pericarditis* in the *Dublin Quarterly Journal of Medicine*. Dr. Stokes does not give any case of pneumo-pericardium from fistula, as occurring in his own experience. Reference is made by him to cases reported by Dr. Graves and Dr. McDowell. See *Diseases of the Chest*, vol. ii. page 23, &c.—ED.]

Selections from Recent Contributions TO PHARMACY AND MATERIA MEDICA.

(Continued from page 254.)

Extemporaneous preparation of Chlorine as a Disinfectant.—Chloride of lime, which is generally employed when it is desirable to disengage chlorine for the purpose of disinfecting an apartment, presents the inconvenience of becoming rapidly exhausted. M. Lambossy proposes as a substitute the following preparation, as simple as it is inexpensive:—Take of common salt, two tablespoonfuls; red oxide of lead, two teaspoonfuls; sulphuric acid of commerce, one liqueur-glassful; cold water, one quart. Mix the red lead with the salt, and introduce the entire into a bottle filled with water; afterwards add, by degrees, the sulphuric acid, and shake frequently. Reaction commences immediately, and is completed in a few minutes. Sulphate of lead is formed and precipitated, as well as sulphate of soda and chlorine, which remain in solution. The last named, which gives the liquid a yellow colour, is disengaged as soon as the bottle is opened. To produce a rapid disengagement, the fluid is poured into flat plates, so as to afford a large surface for evaporation.—*Bulletin Général de Thérapeutique*, 15th July, 1857, p. 33.

Santonate of Quina and of Cinchonia. By M. Pavcai.—It is well known that santonine is a substance analogous to the fatty acids, approximating in a certain degree to the ethereal oils, without acid reaction, but forming with bases (potassa, soda, magnesia, baryta) crystallized salts. It also yields similar compounds with the two alkaloids mentioned above. In order to form such combinations the author takes pure santonine and pure cinchonia, of each thirteen drachms; purified ivory black, two and a-half drachms; spirit of wine, (specific gravity 837°,) thirty-two ounces; he boils the entire in a small alembic, which he keeps closed for some minutes—filters the boiling solution through paper; distils it at a moderate heat in a water bath, until it is reduced to about six ounces; it is then withdrawn from the bath and left in a cool place for twenty-four hours, when the santonate of cinchonia crystallizes, and is collected on a filter at the ordinary temperature; the mother liquor, containing a certain quantity of the salt, may be employed for other preparations. If the pulverized salt be heated for some minutes in a glass matrass, with water slightly acidulated with sulphuric acid, santonine is precipitated.—*Ibid.* page 34, from the *Répertoire de Pharmacie*.

Chalybeate Mixture and artificial Chalybeate Baths.—We are indebted to M. Lambossy, of Nyon, for the two following formulæ:—

Chalybeate Mixture.—The two following solutions are to be sent to the patient: No. 1.—Take of pure protosulphate of iron, two and a half drachms; distilled or No. 2.—Take of carbonate of soda, half an ounce; rain water, eight ounces; dissolve and cork closely. distilled or rain water, eight ounces; dissolve.

To make use of the foregoing, pour a large teaspoonful of each solution into a glass of cold water; on shaking the mixture a greenish-white precipitate is obtained, which it is of importance to swallow before it changes colour. Seltzer water, soda water, and especially white wine, are the beverages which patients prefer to substitute as vehicles for the chalybeate, for plain or sweetened cold water.

Dose.—A large teaspoonful of each solution three times a day; after a few days the dose may be doubled.

Chalybeate Baths.—Take five or six ordinary quart bottles, fill them with vinegar, and add to each three or four handfuls of filings, or better, turnings of iron; leave the bottles open and exposed to the air; the reaction is terminated when the liquor has acquired the taste of ink (acetate of iron).

Proportion for a bath, the fluid contents of one bottle. Duration of the bath, from one to two hours. The iron is to be left in the bottle and may be used again by adding a fresh proportion of vinegar. The water of the bath may be made to answer several times by adding merely half a bottle of the above liquid.—*Ibid.* page 71.

Adulteration of Sulphate of Quina with Sulphate of Aricine.—M. Ascoop has just met a specimen of sulphate of quina adulterated with sulphate of aricine. This fraud is the more difficult to detect (several pharmacists had passed the specimen alluded to as good), inasmuch as when examined by Liebig's process, recommended in the *Nouvelle Pharmacopée*, the sulphate in question presents the character of a genuine product, aricine being soluble in sulphuric ether as well as quina. It is only by evaporating the ethereal solution, and heating the dry residue with concentrated nitric acid, that the falsification can be discovered.—*Ibid.* p. 72, from the *Journal de Médecine de Bruxelles*.

On the Preparation of Lozenges of Pepsin.—The services rendered by pepsin have led to the endeavour to ascertain the most agreeable form for administering the medicine to children. M. Corvisart, to whom we owe this valuable therapeutic acquisition, thought he had resolved the problem by having a syrup of cherries, with pepsin as the base, prepared. The study of the reaction excited between sugar and pepsin, have shown M. Berthé, that a portion of the new medicinal agent was modified and transformed into glucose and lactic acid. In consequence of this result, this distinguished pharmacien has taxed his ingenuity to discover another pharmaceutical form which should preserve the pepsin from any change. The presence of water being the principal cause of the alteration in question, M. Berthé has been led to select the form of lozenges. The following is the mode of preparation he has adopted:—

A firm paste is made in the usual way, with mucilage of gum arabic, and aromatised with a few drops of essence of lemon; when the mass is perfectly homogeneous, four grains of amylaceous pepsin are added for each lozenge; the mass is then divided in the ordinary manner, and the lozenges placed in a stove heated to from 77° to 86° F.

Dessication, under these circumstances, takes place very rapidly, and the lozenges obtained, which are very agreeable to the taste, do not attract moisture.—*Ibid.* page 176.

On the preparation of Iodide of Chloride of Mercury. By M. Gobley.—The attention of physicians has lately been called anew to a compound discovered in 1847 by M. Boutigny, and which received from him the above denomination. The elements used in its preparation are, as is well known, protochloride of mercury and iodine, in the proportion of one equivalent of iodine to two equivalents of the protochloride. The compound consists of a mixture of calomel, biniodide and bichloride of mercury, and is consequently less active than these two latter salts, but is more active than the protiodide and protochloride of the same metal. It is at present very highly recommended in certain cutaneous affections, and especially in acne.

When we place iodine and protochloride of mercury in separate vessels under a receiver, we observe the chloride, by degrees, assume a red colour, which gradually increases in intensity. Heat and light exercise a great influence on the rapidity of the reaction. But as a very long time is always required for the volatilization and absorption of the whole of the iodine, M. Boutigny has recommended the following process for the more speedy preparation of the compound. Calomel in the state of coarse powder is introduced into an assayer's matrass, and gently heated until it begins to sublime; iodine is then added in small proportions, and the combination is effected with noise, without sensible loss of iodine. If, on the contrary, the iodine were

mixed with the calomel, before being introduced into the matras, a considerable portion of the iodine would be volatilized, and we should obtain only a mixture in uncertain proportions, and consequently capable of affording only an uncertain effect.

This process, nevertheless, presents some difficulty in its execution, and requires a certain amount of practice for its successful accomplishment. M. Perrera, in a very interesting note, has proposed to substitute for the iodide of chloride of mercury a simple mixture of iodine with calomel. For myself, I have endeavoured to render M. Boutigny's process more practical and easier of execution, and I have succeeded by operating on only small quantities at a time. The combination of the two bodies then takes place with the greatest ease, and without the least loss of iodine. The following is the mode of proceeding :—

Take sublimed calomel - - - 90 grains.
 „ Iodine - - - 31 „

The iodine is reduced to powder in a mortar, mixed with the calomel, and the mixture is introduced into a small glass matras by means of a paper groove, so arranged as to carry the powder to the bottom of the vessel. The latter is then placed on hot sand, and after the lapse of some moments, the mass assumes a greenish tint and subsequently fuses. On withdrawing the matras from the sand, the mass quickly solidifies. During this operation, which does not last more than a few moments, and which can be frequently repeated in a very short time, no vapour of iodine is disengaged, and the combination takes place noiselessly.

The product is at first greenish, in the air it becomes gradually red, and is finally perfectly red. The process I propose is very easy of execution, and it appears to me preferable to that of M. Perrera, because it yields a product completely identical to that of M. Boutigny. The iodide of chloride of mercury is employed in the form of ointment and of pills. The following is the usual form of the ointment :—

Take of powdered iodide of chloride of mercury, twelve grains; lard, two ounces; mix carefully.

The pills are composed of iodide of chloride of mercury, four grains; powdered gum arabic, sixteen grains; crumb of bread, two and a-half drachms; orange flour water, as much as may be sufficient; to be divided into one hundred pills.

The foregoing are M. Boutigny's formulæ.

The iodide of chloride of mercury is a very active medicine, the effects of which should be carefully watched.—*Ibid.* p. 216.

[Some additional remarks are appended to the foregoing, which further tend to show that the composition of the iodide of chloride of mercury is liable to great uncertainty; and as a slight variation in the constitution of this preparation would cause a very great difference in its effects, its use as a remedial agent is probably inadvisable.—TRANSLATOR.]

On a new mode of preparing Mercurial Ointment. By M. Coldefier, Chemist at Geneva.—The process I am about to describe is the result of a discovery due solely to chance. In the course of one of my investigations on ozone, on approaching my apparatus with a candle in my hand, in order the better to observe the progress of the experiment, some drops of tallow fell into a capsule containing mercury, heated by the current of a voltaic pile. I was annoyed at my awkwardness, but what was my astonishment, when I saw my globule of tallow assume a gyratory movement, and becoming grey coloured; the rapidity of the motion increased with the coloration. I intercepted the current and the globule stopped; I took it up cautiously with a little analysis spoon, and satisfied myself, after it cooled, that I had a small quantity of perfectly prepared mercurial ointment, in which it was impossible to perceive, even with the aid of a double achromatic lens, the most minute metallic globule.

It naturally occurred to me that this phenomenon

could be produced only by the presence of the ozone, by which the mercury was surrounded. In fact, the tallow having become ozonised in an atmosphere of this gas, absorbed the mercury by means of a purely mechanical action, that is to say, by the friction of the adipose spheroid upon the metal.

In a word, omitting all description of my numerous experiments on the subject, I may state that I eventually devised the following formula, the result of which is as certain as the process is easy of execution :—

Put into a large porcelain capsule sixteen ounces of lard perforated with holes, so as to increase the extent of surface, and place half an ounce of phosphorus in a vessel suspended on a thread above the lard; cover the whole with a glass receiver, and at the end of a fortnight ozonization is complete. This lard, so prepared, is introduced into a wide-mouthed bottle, and melted on a sand-bath, at a temperature of 194° F. Four ounces of mercury are now gently heated, and rapidly poured into the lard; the vessel is then briskly agitated for some minutes, and the operation is terminated by quickly plunging the bottle into a vessel of cold water.—*Ibid.* p. 271.

Local application in Eczema of the Face in Children. Dr. Behrend, in a note on the treatment of eczema, recommends the employment of the following combination as a remedy for the numerous scales which frequently cover the face of children :—Cod liver oil, half an ounce; carbonate of soda, half a drachm. Mix.—*Ibid.* p. 272.

Bibliography.

On the transmission from Parent to Offspring of new forms of Disease; and of morbid taints and tendencies. By JAMES WHITEHEAD, M.B., F.R.C.S., M.R.I., &c., &c. Second Edition.

There is no subject within the wide domain of medicine, of greater interest to the philosophic physician than the transmission of taints from parent to offspring; nor is there one which has stronger claims on the consideration of all who desire thoroughly to investigate disease, and to learn its appropriate treatment.

We have been much gratified, and we may add, that we have moreover received valuable information, from a careful perusal of the admirable work which we now bring under the notice of our readers.

The task which Dr. Whitehead proposed to himself in the work before us, has been performed in a manner worthy of its importance; and in according this meed of praise, we do not think we can say more to recommend it to the profession.

Dr. Whitehead commences with some remarks on the origin and varieties of races into which the human family is divided, and refers to the resemblance of the offspring to the parent stock which is preserved through many generations. "Parents live again in their children."

In illustration of this fact, numerous proofs are adduced, exhibiting the tendency in the offspring to perpetuate even the peculiarities of the parents, and reference is also made to some cases in which connate deficiencies have been continued hereditarily.

Dr. Whitehead then proceeds to consider the diseases most likely to be transmitted from parent to child; and we shall quote his own words, as giving the best idea of the scope and intention of his inquiries. "Hereditary affections are susceptible of arrangement, as regards their mode of origin, under two heads, sufficiently distinct the one from the other; those, namely, which are induced by faulty habit, the influences of climate, ill-assorted marriages, and other extraneous agencies, and those which result from the introduction of a morbid

poison into the system." With the latter is the business of the present investigations.

It is needless to go into an enumeration of the various morbid states which are admitted by all who are conversant with disease, as having an hereditary origin. Every physician of experience and observation can supply facts corroborative of the many striking proofs of the transmission of taints to families. Some diseases are so well known to be propagated from generation to generation, that even non-medical men are well aware of the fact. Gout and insanity may be mentioned under this category.

With reference to the hereditary nature of insanity, the accumulated experience of all who have devoted themselves to psychological medicine, abundantly proves how constantly mental maladies are transmitted.

Perhaps nothing conduces more to the transmission of taints than the frequent intermarriage of near relatives, and ill-assorted unions.

Dr. Whitehead makes some excellent remarks upon this subject; and speaking of the syphilitic virus being propagated from parents to children, he says:—"Portal mentions a town in the department of Paris which was full of these various evils, more or less resembling scrofula, the complaints having originated out of two or three bad marriages; the children of these connexions intermarried, and thus the hereditary diseases were successively multiplied." "These examples (Portal observes) more and more evince the propriety of watching over the marriages, to prevent effects so direful to the human race."

With respect to insanity, Dr. Nugent, in his admirable report on the Lunatic Asylums of Ireland, 1857, observes—"Hereditary predisposition, and intemperance, would seem to be the two great feeders, if the term may be used, to lunatic asylums. In an aggregate of 3056 individuals, we find, of the 2,146 where causes were assigned, no less than 997 under these denominations, 506 of the former, 491 of the latter, or 46 per cent. As regards the cases where we had no definite information, it is legitimate to conclude that the same proportion as in the assignable, exists. Hence of the whole population in asylums, 1,790 comes within two categories."

We regret that our space does not admit of our making a lengthened abstract of Dr. Whitehead's observations on the transmission of syphilis, and upon the treatment which he adopted in some cases which he relates, and which fully bears him out in strongly advocating the remedial measures which in his hands have been fraught with such good results.

One case illustrative of the value of *free mercurialization* we shall notice. After detailing the history of a married pair in whom a syphilitic taint existed, and its influence on their progeny, he concludes his narrative in these words:—

"Thus the husband, for ten and a-half, and the wife for the first eight years of her married life, had been constantly ailing; and the fruit of seven pregnancies in succession had perished. Since treatment, their health has not been disturbed by an unfavourable symptom, and each of the two last pregnancies has ended favourably, at full terms, the children still living."

The observations of Dr. Whitehead on the alleged injurious effects of mercury, are most valuable, and eminently practical; and we may add that our own experience is fully in accordance with the views brought under our notice in the work which we have thus briefly introduced to our readers, and which we have no hesitation in recommending as the production of a sound thinker, and of an able and accomplished physician.

Transactions of the County and City of Cork Medical and Surgical Society—Session 1856-57.

A reprint of the proceedings of this very valuable Society from the *Dublin Quarterly Journal of Medicine*.

We would direct special attention to the papers by Dr. Hobart on tetanus; Dr. Harvey's case of recovery from ruptured uterus; and Dr. O'Connor's cases of poisoning by tincture of aconite.

The Uraemic Convulsions of Pregnancy, Parturition, and Childbed. By Dr. CARL R. BRAUN, Professor of Midwifery, Vienna. Translated from the German, with Notes, by J. MATTHEWS DUNCAN, F.R.C.P.E., &c. Edinburgh: Sutherland & Knox, 1857. Royal 8vo. pp 71.

This volume is a translation of a single chapter of a new text book of midwifery by Dr. Braun. It appeared to Dr. Duncan so valuable for its completeness and erudition, that he published the translation of it in the *Edinburgh Medical Journal*, and now republishes it in a separate form. Its value is greatly enhanced by the translators' own notes and annotations.

The true eclampsia or puerperal convulsion, is, according to Dr. Braun, simply the result of uraemic intoxication in Bright's disease occurring during pregnancy. This view of its pathology has been strongly maintained by Frericha, Litzmann, Wieger, Oppolzer, and many others, so that it is not original with the author, though in him it finds a most able advocate. On the other hand it has been assailed by Marchal, Legroux, Stoltz, Levy, Scanzoni, &c. Nevertheless we think that this interpretation of the disease is the most consistent and satisfactory of any that has yet been proposed; though it must yet be confessed that it leaves some points unclarified up.

Dr. Braun enters very minutely into the pathology of Bright's disease, and places before us in a concise manner the results of the most recent investigations and discoveries upon this subject. The treatment of puerperal convulsions, also, is very fully discussed.

On the whole, we regard this treatise as a most valuable addition to obstetric literature, and must express our deep obligations to Dr. Matthews Duncan, for rendering it available to English readers, and enriching its pages from his own stores of practical wisdom.

ON A METHOD OF ASCERTAINING THE VALUE OF THE SEVERAL RE-AGENTS EMPLOYED IN DISCOVERING THE PRESENCE OF SUGAR IN URINE.

We recollect the eagerness with which the discovery of M. Bareswill's potash-copper liquor was received, which, applied to the examination of the urine, enabled us to recognise the presence of the smallest quantity of glucose. His method, though so easy of application, was still further simplified by promoting the reaction, by means of a little caustic potash. It was natural that analytical processes so ready should rapidly become popular. Their use, however, was not so certain as was believed, and a source of error seemed to endanger the prospects of this valuable acquisition.

M. Béhier, at a recent meeting of the Société médicale des Hôpitaux, brought forward so many examples of the uncertainty of these re-agents, that if chemistry had not directly furnished us with the means of counteracting this source of error, these analytical processes should have been rejected from ordinary practice. In fact, M. Béhier has shown that the urine of a very great number of individuals affected with various diseases are coloured by potash, and even produce a precipitate with the potash-copper liquor.

The uncertainty of the re-agent, in these cases, had been observed before, and M. Becquerel had pointed out its cause in his *Traité de chimie pathologique*. The following is, according to this writer, a mode of destroying the elements of the urine, which, as well as sugar, produce the coloration of the fluid, and of restoring to these re-agents all their value:—

"Take a given quantity of urine, one ounce; treat it with a given quantity of lead, say half a drachm; heat the mixture, when an abundant precipitate of a dirty white colour is immediately produced; filter the fluid and treat it with sulphate of soda in excess. If, for example, we have used half a drachm of acetate of lead, we should add a drachm of sulphate of soda; heat the mixture again, sulphate of lead is thrown down; filter anew and we obtain a clear, transparent fluid, containing sugar when it is present, urea, and some trifling salts. Urine so treated reduces potash-copper re-agents, and assumes a brown colour with potash, only when sugar is present. These two re-agents are, therefore, in this manner rendered perfectly reliable.

"If the urine submitted to experiment contains albumen, the solid acetate of lead immediately coagulates this principle, at the same time that it carries down the other organic matters, and we are no longer embarrassed by it in looking for sugar.

"It hence results that whenever we wish to discover the presence of sugar in any urine, whether albuminous or not, we possess in the potash-copper liquor and in potash, two excellent re-agents; but on condition that we previously treat the urine with solid acetate of lead and sulphate of soda, the double reaction of which will remove all the acid or organic foreign matters which might reduce, decolorate or turn green the potash-copper liquor or produce a brown colour."—*Bulletin Général de Thérapeutique*, 30th August, 1857, page 175.

PATHOLOGICAL SOCIETY.

The first meeting of the Dublin Pathological Society, for the Session 1857-8, was held in the Anatomical Theatre of Trinity College, at four o'clock on Saturday, November 28, when the following officers were elected for the ensuing Session:—

President.—Dr. Hutton.

Vice-Presidents.—Dr. Banks, Dr. Fleming, Mr. Hamilton, Dr. Lees, Dr. Beatty, Dr. Mayne.

Council.—* Mr. Adams, * Dr. Corrigan, Sir Philip Crampton, Dr. Churchill, Dr. Gordon, Dr. James S. Hughes, Dr. Law, Dr. Lyons, * Sir H. Marsh, Dr. McDowell, Dr. O'Ferrall, Dr. Smith, and Dr. * Stokes.

* Thus marked have served the office of President.

Honorary Secretary.—Dr. Stokes.

Secretary and Treasurer.—Dr. Smith.

Secretary for Foreign Correspondence.—Dr. Lyons.

The following specimens were presented:—

Dr. NOLAN.—Encephaloid disease of the kidney in a child three years of age.

Mr. SMYLY.—An enchondroma of the finger.—Enlargement of the liver in a case where the thigh had been amputated.

Mr. QUINLAN.—An aneurism of the thoracic aorta.

Dr. CORRIGAN.—Cirrhosis of the lung.—Typhoid pneumonia.

Mr. PORTER.—Case of asphyxia from a piece of meat lodged at the top of the larynx.—A case of gall stones.

APPOINTMENTS.

QUEEN'S HOSPITAL BIRMINGHAM.—Mr. J. S. Gamgee has been elected Surgeon to this Hospital.

Dr. ALDRIDGE has been elected Lecturer on Chemistry in Stevens' Hospital Medical School, in room of Mr. Warren, resigned.

THE NAVY.

ADMIRALTY, NOVEMBER 16.

Surgeon Thomas Seacombe, to the *Imamm*. Assistant Surgeon George W. Sutherland (Acting), to the *Actoon*.

ADMIRALTY, NOVEMBER 18.

Surgeons—John Gallagher, to the *Conjuror*; H. T. S. Beveridge, to the *Cornwallis*; Samuel S. D. Wells, to the *Lapwing*. Assistant Surgeon—J. L. Sands, to the *Lapwing*.

ADMIRALTY, NOVEMBER 21.

Dr. James Carmichael, Surgeon to the *Renown*. Mr. Robert W. Beaumont, Surgeon to the *Lapwing*. Mr. P. W. Goort, Assistant Surgeon to the *Renown*. Mr. W. W. Thompson, Acting Assistant Surgeon to the *Renown*.

ADMIRALTY, NOVEMBER 22.

Surgeon George F. Banks, to the *Alacrity*. P. D. J. Durga (additional), to the *Cornwallis*.

THE ARMY.

WAR OFFICE, FALL-MALL, NOVEMBER 17.

Royal Artillery.—To be Assistant Surgeons—Assistant Surgeon Robert Walter Clifton, from the Staff; Assistant Surgeon Edward Patrick Harris, from the Staff; Henry Folljambe Paterson, Gent.; Robert David Burn, M.D.; Melville George Jones.

16th Foot.—Assistant Surgeon Joseph Richard Kehoe, from the Cape Mounted Riflemen, to be Assistant Surgeon, vice L'Estrange, who exchanges.

2nd West India Regiment.—Assistant Surgeon Charles Bagot, M.B., from the Staff, to be Assistant Surgeon, vice Clutterbuck, appointed to the Staff.

HOSPITAL STAFF.

To be Assistant Surgeons—Charles William Innes Moffatt, M.D., late Acting Assistant Surgeon; Charles Bagot, M.B., vice Hoy, who has resigned; Robert Sutherland, Gent., vice Holloway, promoted on the Staff; Henry Patrickson Gregory, Gent., vice Clark, promoted on the Staff; Francis Madden, Gent., vice Clutterbuck, promoted on the Staff; James Inkson, M.D., vice Irvine, promoted on the Staff; John Gordon Grant, Gent., vice Beveridge, appointed to the 78th Foot; Daniel Murray, M.D., vice McFall, appointed to the 87th Foot; George Parsons Wall, Gent., vice Mullian, appointed to the 81st Foot.

To be Acting Assistant Surgeon—Thomas Callaway, Gent.

WAR OFFICE, FALL-MALL, NOVEMBER 18.

The Queen has been graciously pleased to signify her intention to confer the decoration of the Victoria Cross on (among others) Assistant Surgeon William Henry Thomas Sylvester, 2nd Regiment; date of act of bravery, 8th September, 1855. For going out on the 8th September, 1855, under a heavy fire, in front of the 5th parallel, Right Attack, to a spot near the Redan, where Lieutenant and Adjutant Dyneley was lying, mortally wounded, and for dressing his wounds in that dangerous and exposed situation. N.B.—This officer was mentioned in General Sir James Simpson's despatch of the 18th September, 1855, for his courage in going to the front, under a heavy fire, to assist the wounded.

WAR OFFICE, FALL-MALL, NOVEMBER 24.

37th Foot.—Assistant Surgeon James Inkson, M.D., from the Staff, to be Assistant Surgeon, vice Irwin, deceased.

WAR OFFICE, FALL-MALL, NOVEMBER 27.

HOSPITAL STAFF.

To be Assistant Surgeons to the Forces—William Pirrie, M.D., vice Oliver, appointed to the 60th Foot; Seth Sam, Gent., vice Chapman, appointed to the 37th Foot; Walter John, Gent., vice Mould, appointed to the 83rd Foot; James Jameson, M.D., vice Cruick, appointed to the 86th Foot; John Warren, Gent., vice Brown, appointed to the 86th Foot; William Tanner, Gent., vice Farmer, appointed to the 39th Foot; Henry Cole Peppin, Gent., vice Milne, appointed to the Royal Artillery; George Bonch, Gent., vice Whitley, appointed to the 99th Foot; Charles Bartholomew Mathew, Gent., vice M'Lechle, appointed to the 5th Foot; James Doran, M.D., vice Heard, appointed to the 6th Foot; William Jackson, Gent., vice Wood, appointed to the Royal Artillery; Byng Thomas Giraud, M.D., vice Bell, appointed to the Royal Artillery; William James Cumming, M.D., vice Skinner, appointed to the 93rd Foot.

COMMUNICATIONS RECEIVED

From Dr. O'Donovan; Dr. Hudson; Dr. Gairdner (Edinburgh); Dr. Jamieson; Dr. Kelly; Dr. Alison; Dr. Corrigan; Dr. Moore; Dr. Stokes.

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RICHMOND, WHITWORTH, AND HARD-
WICKE HOSPITALS.

CLINICAL LECTURE.

By DR. CORRIGAN,

Physician in Ordinary to the Queen in Ireland, &c. &c.
(December 2, 1857.)

*Cirrhosis of the Lung—its curative agency in
Phthisis—Displacement of the Heart. Asthe-
nic Pneumonia—peculiarity of its Pathology
and Symptoms—treatment by Quinine.*

The first subject to which I desire to draw your attention is Cirrhosis of the Lung, its nature, and its curative agency in phthisis; and as its nature may not be fully understood, I will devote a short portion of our lecture to an explanation of it.

The name of Cirrhosis was, I believe, first given by Laennec to a peculiar appearance of the liver, of a yellowish hue, which he believed to be owing to the deposition in its texture of a fawn-coloured tubercle. Later observations have, however, taught us, that what Laennec supposed to be tubercles were but the natural acini of the liver, stained yellow by detained bile, and constricted by the fibro-cellular tissue around them, until they assumed on the surface the appearance of myriads of projecting spherical tubercles. The name cirrhosis was continued to be applied to this disease of the liver, although its applicability had ceased to be recognised, as the diseased state was admitted to be a contracted condition of the organ and not the deposition of a new tissue, I therefore adopted the name in describing a state of the lung which, I believe, is analogous to that of the liver adverted to, and which I shall now endeavour to explain to you, illustrating my explanation by the lungs now before you.

In May, 1838, I published my first observations on Cirrhosis of the lung in the *Dublin Journal*, and I have seen no reason to alter the views then put forward.

VOL. IV.

Cirrhosis is not confined to any organ in the body; its action is seen wherever lymph is deposited; its effects vary according to the peculiarity of its seat; its results are, however, apparently varying, or even contradictory, although the results of the same general pathological or physiological law, that lymph, wherever shed, on becoming organised, sets up a contractile action, which may be slow, but which is sure in its effect. Carry the knowledge of this principle with you, and you will find that it will often simplify pathological alterations. You have all seen the unsightly puckered scar in the neck following on the healing of a scrofulous abscess. In such cases the action of cirrhosis has been set up; lymph has been poured out to form a new tissue, as like as nature can make it to the tissue destroyed. The lymph poured out has taken on the action of cirrhosis, or of contraction. Its particles slowly but surely draw together; the surrounding cellular tissue is implicated in it; the skin and cellular tissue around are drawn from all sides towards the original scar; and thus results, from the action of cirrhosis, the unsightly scar arising from the healing of a tubercular abscess. A cicatrix after a burn results from the deposition of lymph, which, on becoming organized, takes on the same action. From all sides this slow but sure contractile action draws in the neighbouring cellular tissue and skin; and thus, in the case of burns in the neck, we see the skin of the face drawn down in the most unsightly way, and in the vicinity of joints, the skin drawn like bands confining their motions. In the instances of lymph deposited in the sub-mucous tissue of the pylorus, the same action gradually contracts the opening, until the passage of food is totally prevented, constituting stricture of the pylorus; and from a similar action arises organic stricture of the urethra. In cases of iritis, where the disease has been neglected, the lymph deposited along the free edge of the iris eventually contracts the pupil, as if a small ring of vulcanized India-rubber had been circled round it; and in cases of narrowed auriculo-ventricular opening, the narrowing arises from the operation of a similar action—deposition of a ring of lymph

B B

around the edge of the valve, and consequent contraction. In some instances, however, the ultimate result appears to be the contrary to narrowing. Thus, if lymph be shed on the free edge of the aortic valves, the contractile action eventually shortens the valves, and prevents them from unfolding to their full extent, thus giving rise to permanent patency; but in this instance, although the ultimate result would, at first sight, appear to be widening, the immediate result is contraction, the same as in all the other instances. One of the most remarkable illustrations of the action of cirrhosis is seen in spontaneous amputation of the limbs of the fœtus. A band or string of lymph is found perhaps two or three times twisted round the limb of a fœtus. If there has not been sufficient time for the full action of cirrhosis in this band of lymph, the fœtus is delivered with merely a very deep indentation in the limb, produced by the contractile agency of the lymph; but if the band has been originally of small circumference; while the limb has been growing, on the one hand, the lymph has been contracting on the other, until, under its constantly-increasing contraction, amputation of the limb has taken place; the band of lymph having produced this effect like a very slowly-acting *ecraseur*; and the child is delivered with the stump actually healed over, and the amputated limb lying separated in the womb.

Let us now come to the illustration before us. The right lung, you observe, is very small in size,—not nearly one-half its natural size; the middle lobe is little more than a mere rudiment. On making a section from top to bottom, the whole lung, including its three lobes, presents a great number of cavities, or dilated bronchial tubes, lined with smooth glistening membrane, while all the intervening portions consists of grey pulmonic tissue, traversed by innumerable grey filamentous bands, running in every direction. All the intervening tissue is impermeable to air, not crepitating, not oedematous, but tough, and quite destitute of blood, so that not a drop escaped on making incisions through it. It is scarcely necessary to observe, that portions of this pulmonic tissue, thus altered, sink in water. The lung thus altered was not rendered solid or carnified by effusion of fluid, for there was no effusion of fluid into the cavity of the pleura, there having been universal adhesion of both pleural surfaces. The lung was not solid from deposition of lymph, as in some stages of pneumonia, for it was not hard nor brittle, nor of natural size. It was, as you see, of very reduced size, and the change appears to be produced by, first, the deposition of lymph through the whole cellular and fibro-cellular tissue of the lung, which then contracting, necessarily draws every portion of the lung towards the root, and thus finally obliterates all the finer bronchial capillaries, reducing the lung to a state which may be illustrated by supposing a sponge to undergo a similar contractile diminution in size, if its particles

were to maintain a constant although slowly contracting action. But while obliteration will be the result on the minute air-tubes, which are not protected by cartilaginous rings, the action will be, in many parts of the lung, to draw towards one another the sides of neighbouring bronchial tubes, by contraction of the new tissue lying between them; and thus in this disease we find, as in the case before us, some of the cavities with the circular fibres of dilated bronchial tubes plainly marked within them.

As this slow contraction of the tissue of the lung proceeds, a space would be left which must be supplied; and hence in cirrhosis of the right lung, as in this case, the heart traverses over, and is found pulsating to the right of the sternum. In this case the heart, you will recollect, was noted during life as pulsating in the right side of the chest, and was one of the signs by which cirrhosis of the lung was diagnosed. In making the *post-mortem* examination, before opening the chest a sharp point was passed down on the right side of the sternum, and it was found to have pierced the right ventricle close to the septum, leaving nearly three inches of the heart to the right of the point pierced; while, in the natural position of the heart, the point in that situation should have pierced merely the edge of the right auricle. When you find the heart beating in the right side of the thorax, you must then, in estimating its value as a sign, remember that the heart may be either pushed over into the right side by effusion into the left, or drawn into it by cirrhosis. In a case of cirrhosis of left lung, I have seen the heart drawn up until it pulsed immediately under the clavicle, where, unless the action of cirrhosis were understood, its pulsations might be mistaken for those of aneurism.

In the upper part of the right lung, occupying its very apex, is a large anfractuous cavity, which there can be no doubt, I think, was originally a tubercular cavity. Its broken and irregular outline, and the absence from around it of the grey tough tissue of the lung, such as found through the other portions of the organ, indicate that there had been great destruction of pulmonic tissue in this part; and the history of the case, which I shall notice shortly, would confirm this view.

If we then consider this case, as there can scarcely be a doubt, to have been originally a case of tubercular disease in the apex of the right lung, we are naturally led to consider what may be the action of cirrhosis in reference to phthisis; and we can, I think, hardly fail to recognise it as a curative agency. Through the whole tissue of the organ, with the most careful examination, we could only discover one solitary speck of tubercular deposition; so that we are reasonably led to conclude that the action of cirrhosis, once set up, extinguished the tubercular action; or, to put it strongly, but not, I believe, less truly, the action of cirrhosis may be considered as hostile to, or counteractive of, tuber-

cular deposition. This would accord with my experience. I do not recollect that I have ever seen tubercles deposited in cirrhotic lung or liver. If this view of the curative agency of cirrhosis be correct, it leads us to attach great value to any indication that can be detected in the progress of chronic phthisis of displacement of the heart, either upwards in left side, or traversing to right side; for such displacement would tell us that cirrhosis had begun, which would extinguish tubercular formation.

I will now merely add the history of the case, which is that of death immediately resulting from ulceration of the cæcum caput coli and ilio-cæcal valve, and its usual concomitant uncontrollable diarrhoea; with its commencement as tubercular pneumonia, and its progress that of phthisis, merging into cirrhosis that would have eventually terminated in recovery, had the circumstances of the patient been such as to have enabled her to command the appliances of comfort and change of air needed in her instance:—

H. D., aged 24; admitted into hospital October 11, 1857; suffering under diarrhoea, cough, and debility. On physical examination, the left side, including the *cardiac region*, was clear on percussion, with exception of apex, which was dull, and over which there was cavernous respiration. The whole of right side of thorax was dull on percussion, with bronchial or cavernous respiration, and the heart pulsated in right side, over an extent two inches to right of sternum, and about third rib. The mammae continued well developed, and there was not the great emaciation that might have been expected from the history of the case, which is as follows:—

She says she was a healthy, strong girl (a book-binder by trade) up to four years ago, when, from sleeping in damp clothes, she caught cold, and was seized with burning pain in her right shoulder, and cough. The cough abated, but the pain continued to annoy her, and she improved each summer, with relapse in winter, until September of 1856, when she entered hospital, and remained in it for four months. She continued an invalid, although better, during last summer, with occasional oedema of feet, until October of this year, when she lost appetite and flesh, and became so much debilitated that she could no longer work, and therefore entered hospital. The immediate cause of rapid sinking and death was the uncontrollable diarrhoea, arising, as already explained in the description of the *post-mortem* appearance, from ulceration of the mucous membrane of cæcum caput coli and ilio-cæcal valve. She died on the 21st November.

I cannot allow this lecture to terminate without bringing under your notice a form of pneumonia and of pleuripneumony that is now, I may say, epidemic among us—asthenic pneumonia. It attacks all ages. It proves fatal either directly in the first stage of congestion—in which it is, indeed, a very fatal disease, the patient dying while the lung is

gorged and dark, from which, on a former occasion of noticing it, I called it Blue pneumonia—or it passes from the first into the third stage, scarcely showing at all the second or hepatized stage. Instead of being seated, like ordinary pneumonia, in the lower lobe, it is more frequently found in the upper lobe. Its symptoms are as peculiar as its pathology.

It is not accompanied with the peculiar calor mordax of skin which is so characteristic of inflammatory or sthenic pneumonia, but, on the contrary, the skin is of its natural temperature, or cooler than natural, and the face rather sallow than otherwise.

Pain is variable, and appears to depend altogether on the degree of inflammation of the pleura; most generally, however, it is not much complained of, the patient describing shortness of breath as his prominent symptom.

One of the most remarkable features connected with it is, the absence, for several days, of any expectoration, and even when this does appear, its being very small in amount, compared with the extent of local disease, as revealed by percussion and auscultation.

Bronchial respiration, and very fine crepitating rattle, are the auscultatory signs developed in the disease.

I have again, as two years ago, to recommend strongly its main treatment by quinine. The general dose which you see administered for an adult is five grains every third hour; and under its exhibition the pulse becomes slow and steady, the respiration free, and rapidly so. If the patient be young, with evidence of capillary congestion generally over the system, the exhibition is preceded by local depletion; but this is rather the exception. The patient, in this treacherous disease, often does not seek admission into hospital, nor advice in private practice, until too late, deceived by the absence of pain, of fever, and of expectoration, and feeling merely debility and shortness of breathing. In the instance which has furnished us an opportunity of examining the disease, the man died within six hours of admission into hospital.

The whole upper lobe of left lung, you observe, is greyish or pale-coloured, quite destitute of air or elasticity, solid like liver to the feel, but at the same time soft and brittle under the finger, with scarcely any evidence of pleuritic inflammation, while the lower lobe remains healthy.

THE YELLOW FEVER AT LISBON.—The number of cases from the outbreak of the epidemic to the end of October has been 7,177, and the deaths, 2,215. The hospitals set aside for yellow fever patients have received 8,068 individuals, 2,449 men and 619 women. The deaths amongst the former were 811, and amongst the latter 188. The relative proportion of the general mortality has been 1 in every 3.24, and of the mortality of the five hospitals 1 in every 3. The epidemic is on the decrease.

**CURSORY REMARKS
ON A SPECIMEN OF
MALIGNANT DISEASE OF THE STOMACH.**

By HENRY KENNEDY, M.B.

(Read before the Medical Association, 2nd Dec., 1857.)

Through the kindness of Dr. Smith I am enabled to lay before the Association a morbid specimen of some interest. It is an example of malignant Disease of the Stomach, but of an unusual form. The patient from whom it was taken was a man above 60, admitted into Dun's Hospital during the past autumn. There was a well defined but extended tumor to be felt during life, and the man suffered more from even the gentlest manipulation than is usual in cases of the kind. He had had vomiting for a considerable period, but this was allayed from the time of his admission into hospital, I believe, by an anodyne liniment applied over the stomach. He was not as much wasted as is common in these cases; nor had the bowels been, in any marked degree, sluggish. He lived but a few days. On making a *post-mortem* examination we found very extensive disease of the stomach. The entire organ was engaged; and this was the feature which makes the case somewhat rare. There is literally not one inch of it which does not present, as you may see, malignant disease. Its character is of the hard scirrhus-like structure, and in this it differs from any other specimen of a similar kind which I have seen; for gelatiniform cancer is, I believe, most common when the whole organ becomes engaged. The stomach has not lost its shape, but it is considerably smaller than natural, and even when taken from the body it did not collapse. This you can understand when I tell you the parietes of the organ were nearly a half-inch thick, and this they preserved almost everywhere. The mucous surface did not give the idea of ulceration at all, but rather of very great hypertrophy. It was, however, at the same time, a very uneven surface. There were no appearances of constriction at either orifice. On taking out the stomach at first, I could not help being struck with its very great likeness to the class of stomachs where something like a gizzard exists naturally, and which probably most present have seen. Except in size, the resemblance is, to my own eye, complete.

But the morbid deposit was not confined to the stomach alone. All the mesenteric glands were more or less indurated, though none had reached any remarkable size. Two small tubercles were in the liver, but it was not otherwise engaged. In addition to what has been stated, I found that the entire of the cellular membrane, lying behind the peritoneum and on the left side, had taken on the morbid change, but here it was more of the lardaceous character. Of this kind it reached literally from the diaphragm down to the pelvis, where it could be seen that the urinary bladder

had also begun to take on the disease. The patient had some symptoms referable to this organ during life, though in a very slight degree. Besides what has been stated, there was also a good deal of passive effusion in the abdomen—more than is usual in cases of the kind.

Such are the details of this specimen, on which the Association will probably allow me to make a few remarks of a cursory nature, not at all connected the one with the other. The point which must first strike us all is the extent to which cases of this kind will go, and yet life may be not only prolonged, but actually carried on as if little were wrong. I recollect a case Mr. Cusack brought before the Pathological Society, where the patient literally was able to use his ordinary food till within a week of his death, and yet the entire stomach was one mass of malignant disease, the mucous membrane being also extensively ulcerated. There are two points which, in a degree, explain these difficulties; first, the freedom of the pyloric orifice; and, secondly, the now ascertained fact that digestion can go on, to a certain extent, below the stomach. If this organ be rendered useless, there is every reason to suppose the powers of the intestines will even be increased beyond the normal limits. But there is a third, and it appears to myself, a most important point, which is never to be overlooked in the explanation of these cases. For want of a better term we are compelled to call this point temperament; and it is really extraordinary what an influence this exercises on disease, I may say, of every kind. Here we have examples of the entire stomach disorganised, and yet the individuals use their ordinary food till within a week of their death. And again, we have cases of suffering prolonged over years, and yet a *post-mortem* examination scarcely enables one to say there is anything wrong with the stomach. This last is not imaginative, but what I have really seen. Truly it behoves us, with such facts before us, to use the extreme of caution in arriving at a diagnosis, in, at least, some of these cases. That the majority can be recognised during life, and more particularly where a tumor may be felt, is certain. But in many instances this is not the case, and then too great caution, I repeat, cannot be exercised. Speaking of the diagnosis, too, reminds me of another way in which an error may be made. The only tangible symptom present may be one which draws off the attention altogether from the stomach. Such a case is where diarrhoea alone exists, and yet where, on *post-mortem* examination, nothing but disease of the stomach is found. Of this I have seen more than one instance, and it seems a point worthy of remembrance.

In the last place, I would advert for a moment to the pulse, as affording assistance in the diagnosis of some of these cases. The general impression, I believe, is that it will tell you nothing; that as the disease is very chronic the pulse will

be slow. Now this may be quite true of the majority of cases; but there is a class of them in which the very contrary state exists, and from first to last the pulse keeps high, from 120 to 130. The disease, in fact, is an acute one, as contra-distinguished from its more ordinary form, whilst the state of the patient is very like what is seen in acute phthisis, where all the symptoms of fever run—as you know—so very high. Of this state, in connexion with malignant disease of the stomach and other organs, I have now seen several instances, and as a knowledge of it has been of use in forming a correct diagnosis, I now mention it as a point worthy of keeping in remembrance.

Speaking of the diagnosis of affections of the stomach, I would advert to the assistance which may be got from the act of inspiration—that is, when a tumor exists. In some instances you are aware that a difficulty exists in distinguishing between an aneurism and other tumor situated in the epigastrium. Now, by making the patient take in a deep breath, the mobility or not of the tumor becomes at once apparent to the hand placed over the region, and hence the diagnosis can be materially assisted, if not entirely cleared up. I may mention in passing, that I have seen one instance where a tumor in the left iliac region was distinctly affected by the act of inspiration. May not this point be brought to bear on the question of the adhesion or not of tumors in this region? one of moment at times to be able to clear up.

In the last place, I would advert to two, and only two, points in the treatment of malignant disease of the stomach, or indeed elsewhere. I shall put them in the form of queries. Have we not lost sight too much of the treatment of malignant disease by local bleedings? It appears to me we have; and a valuable means of treating these affections seems to be forgotten, though it has been recommended years ago by able and practical men. It will not be supposed that I speak of the remedy with any hope of leading to a cure, but only as a means of affording relief, and this I have seen it do on several occasions and in a very marked way; in fact, after all other remedies, including opium and chloroform, had utterly failed. This subject I would enlarge upon with ease, but allusion to it here is sufficient for my purpose.

On the second point, as regards treatment, I would ask, are the preparations of iron as freely used in malignant diseases as they deserve to be? I must answer this in the negative, as I cannot have a shadow of doubt on my own mind that this medicine is capable of doing much in these cases. It is to the late Mr. Carmichael that we owe our knowledge on this subject. I am aware, however, that iron had been recommended long before his time, as indeed, he states in his work, still he has the credit of bringing it before the profession in a way worthy of all imitation, and

showing, as it appears to myself, on the clearest grounds, the relief which it is capable of affording in many of these distressing cases. To say that iron in any form will cure cancer, would be going farther than facts would probably justify, but that great relief, extending over months and months, can be obtained from its use, I have no doubt. I am not, however, going to enter further on the subject here.

Proceedings of Societies.

PATHOLOGICAL SOCIETY OF DUBLIN.

The first meeting of this Society for the Session 1857–58 was held on Saturday, November 28,

The President, Dr. CORRIGAN, in the Chair.

Encephaloid Disease of the Kidney.

DR. NOWLAN said—These morbid specimens were taken from the body of a child, aged three years and six months. The case was first brought under my notice on the 22nd of May last. The child was then suffering from pertussis, and the mother directed my notice to the presence of a tumor in the left lumbar region. It was moveable; being very difficult to detect when the child was lying upon his back, though comparatively easy when he was in the erect posture. The child recovered from the pertussis in the July following, and I then came to consider the tumor carefully. It commenced immediately beneath the false ribs on the left side, and extended obliquely downwards as far as the anterior superior spinous process of the ilium, along Poupart's ligament for two inches, and inwards to the umbilicus. It gave me more the idea of spleen than kidney. When the descending colon became loaded with feces, it could be rolled backwards and forwards upon the surface of the swelling. The presence of this tumor was not attended with the slightest pain, or any other appreciable symptom, or almost any physical sign which might indicate its nature; there was no enlargement either of the superficial veins of the abdomen or of the lymphatic glands above or below Poupart's ligament, and the child's general health did not seem to suffer much. There was no perceptible change until the 11th of August last, when, for the first time, hæmaturia occurred, and at this time I think the child lost five or six ounces of blood. On the 21st of August it recurred; and a third time on the 11th of September. On the 19th of the same month it was attended by a symptom not previously present, viz., pain. Immediately before the hæmaturia came on, the child was seized with severe pain in the umbilical region. It was remarkable that this hæmaturia, instead of tending to debilitate the child, seemed to have the opposite effect, and the application of a few leeches to the seat of pain was invariably attended by marked benefit. On the 28th of September hæmaturia again occurred.

From the first it was my impression that the tumor which existed in the abdomen was caused by a strumous enlargement of the kidney. But Dr. Henry Kennedy, who saw the case with me, said at once that it was encephaloid disease of that organ. I did not see the child again until the 20th of November. When I came into the room I found him bathed in cold perspiration, and labouring under difficulty of breathing; there were signs of capillary bronchitis on the right side; the extremities were cold, lips blue; the child was rapidly sinking. On the next morning the breathing was still very difficult, and he was lying on his face. On the evening of this day he complained of retention of urine; I passed a catheter but found the bladder empty. Next morning the child died, Monday, 2nd. After death the body of the child presented a very wasted appearance, although up to the 14th of October there was no enlargement of the superficial veins of the abdomen. There was enlargement of the inguinal lymphatic glands. On making an incision into the cavity of the abdomen, a tumor, which was the left kidney, greatly enlarged and diseased, came into view. The colon passed across the upper portion of the tumor. When cut into, the organ presented the appearances of encephaloid cancer. There was nothing particular about the renal vein, but the ureter was blocked up by an encephaloid mass. The hollow viscera were apparently free from disease; the mesenteric glands were not enlarged; the right kidney was also similarly diseased and enlarged to three times its natural size. The liver too, was greatly enlarged, and upon its surface there was one or two yellowish spots, indicating the commencement of similar disease in that organ. On opening the cavity of the thorax I found a large irregular medullary growth occupying the anterior mediastinum. The existence of this during life I did not suspect, and its formation fully accounted for the symptoms which the child laboured under on the 20th of November. This mass pressed upon the heart, displacing it downwards towards the spine. There was no trace of disease about the heart. The left lung was a mass of encephaloid disease, compressed towards the spine by pleuritic effusion; a small portion of the apex was free from disease. The pleura contained about a pint of fluid; the middle lobe of the right lung presented on its anterior surface a pedunculated encephaloid growth, about the size of a small orange, and the posterior surface of the upper lobe presented a similar tumor; the remaining portion of lung seemed free from disease, but presented well marked evidence of capillary bronchitis. I think this case is one of interest, for I believe that primary encephaloid cancer affecting the kidneys is of rare occurrence; and I find on looking into Mr. Walshe's work, that forty cases of cancerous disease of this organ, but three have occurred at this early age, it being generally attendant on more advanced years.

Aneurism of the Arch of the Aorta.

Dr. QUINLAN, on the part of Dr. O'FERRALL, exhibited an aneurism of the arch of the aorta, taken from the body of a man aged 40, who was admitted into St. Vincent's Hospital on November 3rd. On his admission the patient complained of difficulty of breathing and of swallowing, which had, he stated, commenced about five months before. He had fits of dyspnoea, which had latterly increased in duration and severity. His voice was scarcely audible; this symptom, however, was of a rather intermittent character. The existence of aneurism, or some other thoracic tumor, was surmised, and, on a careful examination, it was found that both lungs were clear upon percussion; the action of the right lung was puerile, and the vesicular murmur healthy; scarcely any respiratory murmur could be detected in the left lung. The radial pulses were equal. There was no dropsy, or other sign of venous pressure. No direct stethoscopic sign of an aneurism could be detected. There was no abnormal dullness about the sternum. On the Tuesday morning after his admission his respiration suddenly became laboured, and with considerable stridor; his pulse became quick and weak, and his skin covered with clammy sweat. The propriety of performing the operation of tracheotomy was considered, but was abandoned, inasmuch as the respiratory murmur was perfectly audible in the right lung. Stimulants were administered, but the patient gradually sank, and died about four hours after the supervention of the fit. On making a *post-mortem* examination, an aneurism of the arch of the aorta was discovered, as large as a middle-sized apple, situated at the junction of the transverse and descending portions. The aneurism pressed upon and flattened the left bronchus. At the point of pressure it ulcerated into the bronchial tube, between two of its rings, slightly eroding the upper of them, and had almost completely opened through. The left lung was healthy, but somewhat contracted. The larynx and trachea were healthy and unobstructed. The left recurrent nerve was pressed between the bronchus and the tumor. The heart was hypertrophied; the left ventricle contained about three ounces of blood.

In connexion with this case, Dr. Quinlan remarked, that the fact of blood being contained in the left ventricle, along with the other pathological appearances, showed that the man had died, not of asphyxia, but of inability on the part of the heart to propel its contents; and that this proved the correctness of the decision as to the impropriety of operative interference.

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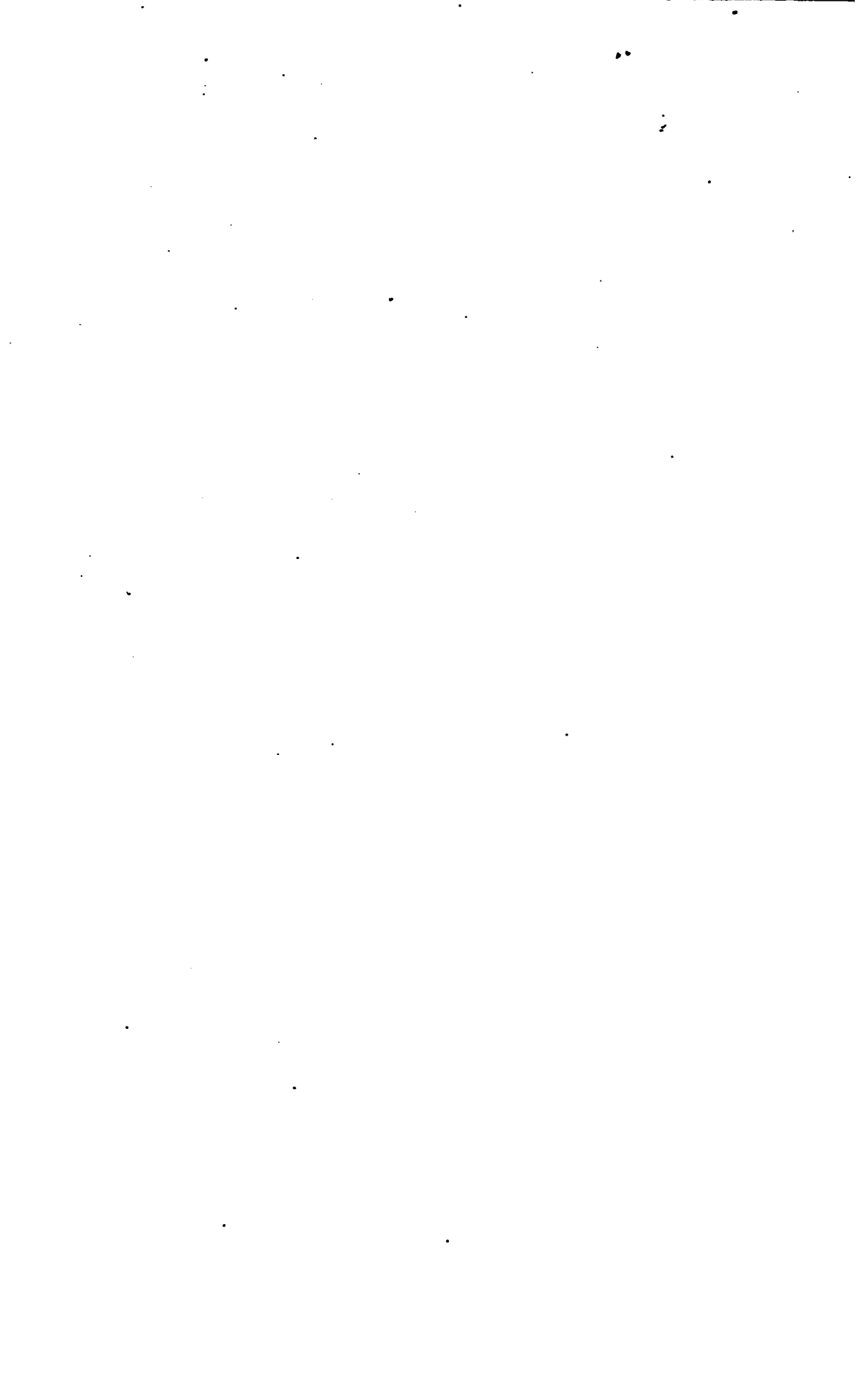
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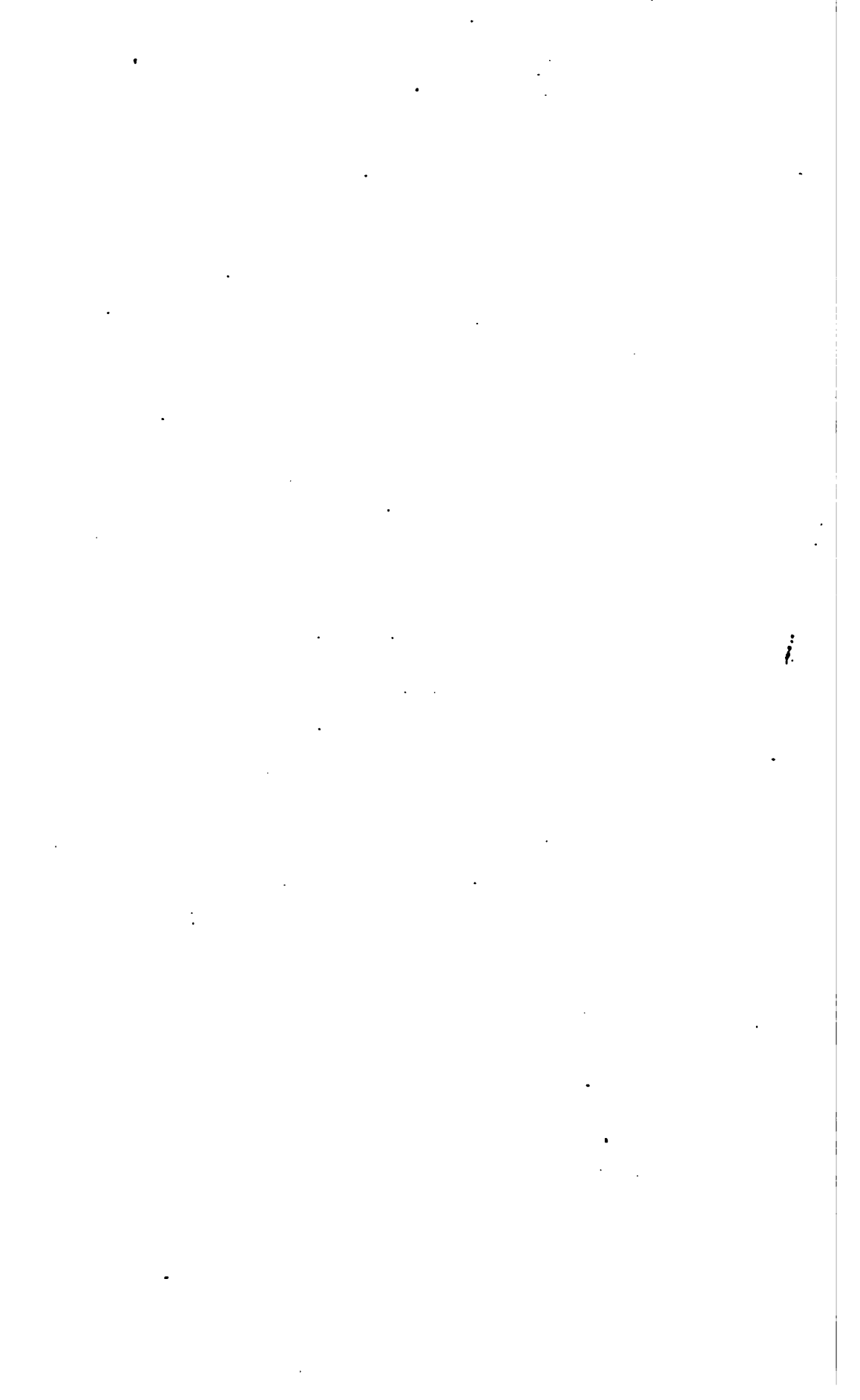
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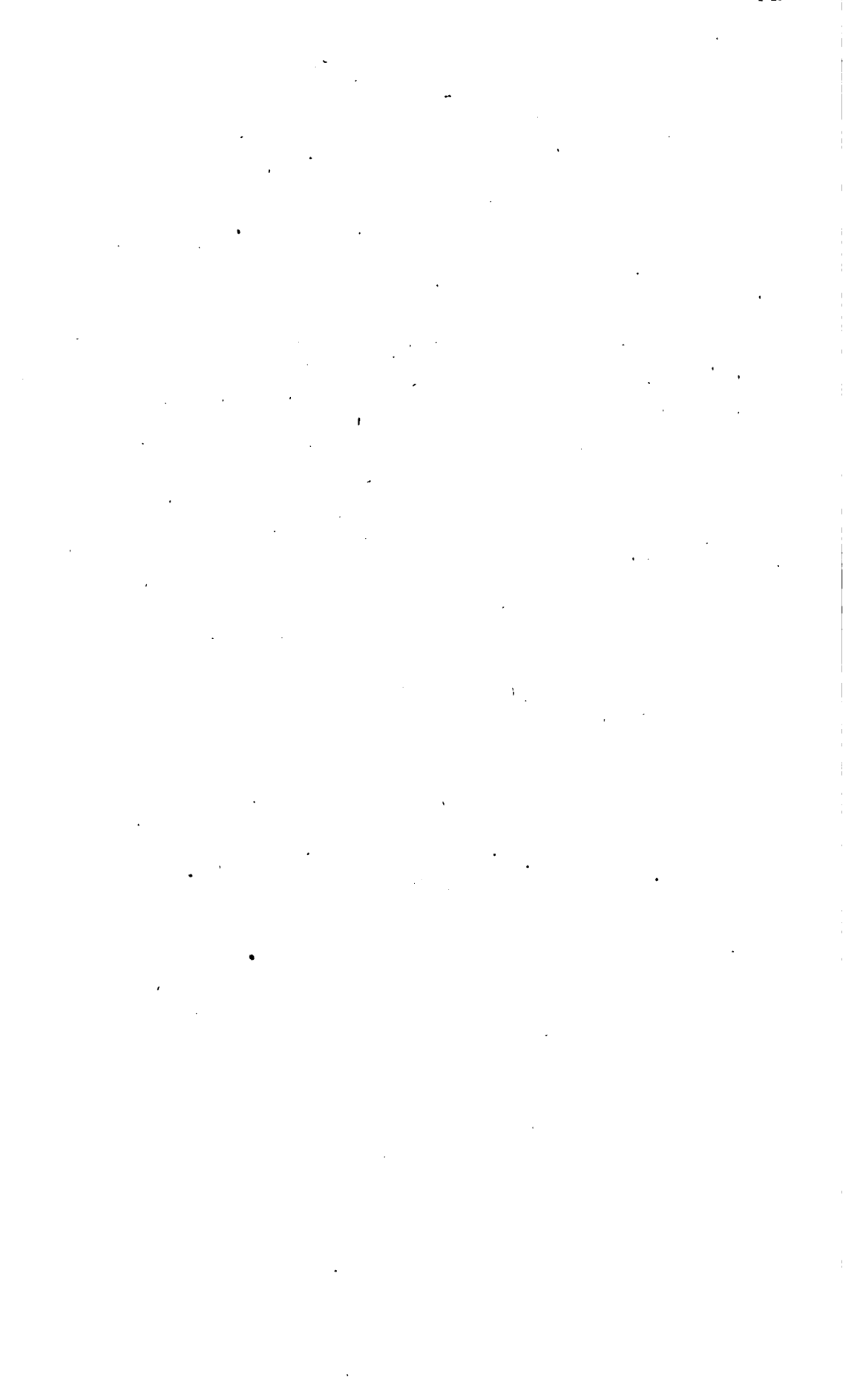
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